PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

VOL. 38, NO. 2 FEBRUARY 1946

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PUBLIC HEALTH NURSING

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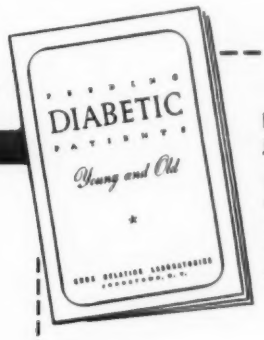

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Job or School: When and Where?

FOR SEVERAL important reasons, it is essential that the veteran nurse returning to professional service in this country give consideration to all the factors involved before she decides how and where she will spend the next year.

While at first glance her obvious choice, in view of the added benefits provided by the amended G.I. Bill of Rights (page 65), might seem to be to take advantage of the opportunities for study now, sober reflection reveals several significant questions she will want to consider before she makes her decision. She may well ask herself:

1. In what field of nursing am I most interested?
2. For which field has my preparation up to this time prepared me best?
3. What are the most pressing needs of nursing as a whole?
4. In which field would my contribution count most in this period of reconstruction?

Some of the universities are reporting a very great interest on the part of veterans in one or two fields to the exclusion of others. We were forewarned of this situation by data on postwar plans of Army nurses collected by the American Red Cross. These indicated that 13 percent of the entire group planned to go into public health nursing when they returned to this country, or more than twice the number who left public health nursing positions to enter military service. Eleven percent of the Army nurses said they desired professional preparation in public health nursing. If these figures carry through, and they do not include Navy nurses, we may expect at least 7,800 veteran nurses eventually seeking public health nursing jobs. And some 6,000 will want courses in public health nursing—this training to be initiated within four years and completed within nine years after discharge, under the amended law.

It is readily understandable that if a large number of qualified nurses leave other fields to enter public health nursing, this field will profit. But if carried too far the result might be tragic for the public interest as well as for nursing as a whole, particularly the schools of nursing on which all of us depend for future nurses. If the great majority should elect to go back into the schools of nursing, it would be equally disastrous for public health nursing and for other special fields. To leave the needs of any one field unmet will retard the development not only of that one field but of all nursing.

By the same token, if all veteran nurses elect to study during this first year, the needs of nursing service, whether in hospitals, public health, industry, or schools, will continue to suffer under the heavy handicap of inadequate personnel—inadequate both in quantity and quality.

Then, too, individual needs and preferences must be satisfied.

Review of personal interviews with some 100 veterans and correspondence with four or five times that number at the NOPHN office reveal that inquirers are of three types: (1) the former public health nurse who wants to move on to something else (2) the graduate nurse who desires to enter public health nursing (3) the nurse veteran who is just shopping around for general information.

Shall I go to school or wait? Almost every returning veteran nurse is debating this question. If wise, she is taking into account several factors — among others, health, the amount of her previous training and experience, her future goal. For some nurses there is value in waiting before going to school, even before taking a job. Many are physically tired, emotionally at loose ends. For all then attention to health is the first step. When the individual nurse is ready she may find that taking a congenial position instead of going to school may help her to make a more speedy readjustment to civilian life. Experience on the job may make later educational training more meaningful, as it will enable her to try out a particular field before she selects a school and the specific advanced training

she needs. Incidentally she will avoid the possibility that her admittance to the school of her choice may be delayed by present crowding.

The nurse with former public health nursing background will also want to ask herself, do I need further training now? Her war experience to greater or less degree was educational; therefore, she is better prepared now than before the war. In fact, some military experience has been considered of sufficient educational value to warrant academic credit, and this is another question returning veterans are asking as related to their problems.

Securing professional educational credit for war work is difficult. In peacetime, a principle accepted by the Collegiate Council (comprising the directors of the 34 approved programs) has been that credit should be granted for field experience in an agency only if it is taken as an integral part of the total program, and under the auspices of the university. The student registers for it just as she does for any course in theory. If the student comes to the university after having had an experience in public health nursing which is the the equivalent or better than that offered by the university, judged by the university's standards, the student may be granted an exemption from the field experience requirement but not credit.

This principle can be applied to military experience. The degree of its similarity to the experience required by the university, time spent, type of position, responsibility carried, and other factors should be considered. If military experience meets the university field experience requirement — as might, for example, the public health nursing done by Army nurses in Occupied Germany, the veteran may well be given an exemption. In like manner, if any of the theoretical instruction is the same or closely akin to that required by the university, it should be considered for its credit value by transfer.

If the graduate nurse is without public health nursing training or experience, what are her problems? Has she analyzed her reasons for wanting to go into public health nursing? To some, the leaving of one field to enter another is the apparent escape from unsatisfying work, or perhaps from certain disliked personnel policies in the old field. The reasons may be good for the particular veteran but they may be based on a mistaken idea of the desired new field. Before she makes a change, this nurse must be certain she knows what is involved in the change—the nature of the work, the professional level to which she is eligible, her general chances of success. She must recognize that the change may mean a demotion—the supervisor in one field is not always qualified for a supervisory position in another. As the public health nurse who went into the Army found she must learn clinical techniques all over again, just so the nurse who has never worked out of the hospital must learn public health nursing from the ground up if she wishes to serve adequately in that field.

The location of available public health nursing positions offers a further problem to returning veterans. As has been said before it has never been easy to find the *right* job. Nurses today are often puzzled by the seeming difficulty of placement in the midst of what is said to be vast expansion of public health and a large unsatisfied demand for public health nurses in both urban and rural areas. Many nurses prefer to remain in the large cities and such vacancies will doubtless be filled first. Unless a large number choose to serve in the smaller towns and in county services these areas will continue to suffer from lack of needed family nursing service.

As ever, the situation calls for patience and careful individual thinking.

Social Hygiene Day

FEBRUARY 6, 1946, was National Social Hygiene Day, a reminder to the general public that venereal disease is still another great unsolved problem of public health, a danger against which we must together exercise continuous and increasing vigilance. To public health nurses and their agencies the day was a challenge to more effective venereal disease service during all the days of the year, —better case finding and follow up, more preventive teaching, greater helpfulness to families in solving the grave problems which accompany the venereal diseases.

(Continued on page 62)

And It's an Exciting Future!

By ELIZABETH GORDON FOX, R.N.

AND SUPERVISORY STAFF

SHORTLY AFTER the arrival of the November issue of PUBLIC HEALTH NURSING, we took up Dr. Joseph Mountin's provocative article, "The Future of Public Health Nursing," for discussion in our regular Friday morning conference—we being the administrators, consultants, and supervisors of the New Haven Visiting Nurse Association.

The vigor and seriousness of the discussion which followed would have pleased Dr. Mountin, we fancy, if one of his objects is to sharpen our thinking. In general, we find ourselves in agreement with his analysis of present and prospective trends in the communicable diseases of childhood and in the increased hospitalization of patients having acute illness and of practically all maternity cases. Our experience in New Haven bears him out.

We are interested in his thesis that public health purposes in the future will be served largely by health education, institutionalization, specialization, and fragmentation, and that traditional public health nursing services will thereby be greatly narrowed and perhaps eventually outmoded. There is certainly room for much more health education covering "both general health information and subject matter applicable to particular disease conditions,"* if it is scientifically accurate and psychologically sound, and we welcome it as laying the ground for the individual work that must follow—just as the foot soldier finds his task made easier by the artillery barrage that prepares the way for him.

Dr. Mountin's fear that public health nurses will resist the introduction of health educators and auxiliary workers into the public health field seems to us unfounded. Our thesis is that there is a place for both of these groups, but we see them as supplementing rather than to any degree supplanting public health nursing. We think of health educators in the category of organizers and molders of public opinion, their job being to plan programs, attract audiences, secure professionals as teachers, and translate scientific material into popular language for the radio, newspapers, pamphlets, and articles. Another aspect of their work is to watch and to help combat commercial advertising which may be detrimental to health.

In larger communities, at least, it may well be economical and useful, in terms of more complete nursing care, to add visiting attendants to nursing staffs. Certain it is that we already recognize a pressing need for a high type of housekeeper service to step into the gap in the home when the mother is temporarily incapacitated.

While it is true that auxiliary services might well be developed to supplement nursing care for the chronically ill, there would still be need for the nurse, in many instances, for supportive treatment for both patient and family. Where family problems are complicated, it is a question to what extent auxiliary nursing service could be used. For too long we have thought of the care of these patients as routine bedside nursing, overlooking the fact that an alert nurse may see many ways of adding to the patient's comfort and peace of mind, as well as of protecting others in the family from undue strain.

We have long been working with nutritionists, with medical, psychiatric, and family

Miss Fox is executive director, Visiting Nurse Association, New Haven, Connecticut.

*Quotations are from Dr. Mountin unless otherwise specified.

social workers, and find them all indispensable partners.

WHERE WE DIFFER with Dr. Mountin is in his concept of man as a wholly rational being, and in his, to us, old-fashioned idea of public health nursing. He himself provides the clue to the modern and future practice of public health nursing, though he does not seem to be aware of the significance of his own words. He says: ". . . . for further advancement of public health the individual must be both informed and *motivated* in matters affecting his personal health." ". . . he (the sanitary inspector) lacked what it took *to change the habits and practices* of the family." "Once the physician has determined the course of action for the patient, the problem will hinge largely on *re-training and social adjustment.*"

Before we can understand how motivation, change of habits and practices and social adjustment take place, we must understand man himself. Looking at the behavior of man today, one must question to what extent he is a wholly rational individual who, given knowledge, will act wisely. On the contrary, conduct appears to be dictated much of the time by emotion rather than reason. And motivation springs from attitudes and relationships which, in turn, are derived largely, we are told, from the unconscious. Even with the most reasonable, there is often a considerable time lag between intellectual acceptance of an idea and action in response to it, especially when the idea is unpalatable.

Much has been said about the need of treating the child as a whole child; this applies to man at all ages. Neither illness nor health exists apart from its host, the living organism. Both affect and are affected by all sides of man's being as a living, thinking, feeling and reacting individual. The wholeness—not merely segments—of his being must be reckoned with in dealing with his illness or in fostering his health.

As a social animal, man is part of a family. This has been admirably stated by Mr. Bailey Burritt: "The maintenance of health and the prevention of disease and all medical care has to deal with an individual as an integral part of a biological unit, the family. . . . It is an essential basic concept in the newer advances in the field of public health. It is as a member of a family unit that a babe is born and the infant and child is nourished. His health for his whole life span is influenced greatly—in some instances predetermined—by beneficial or adverse influences centering in the home and family. The nutrition of all members of the family is more or less controlled by the family unit and not by each individual member. The habits of the family as a whole determine to a large extent the rest and recreation of its members. Health teaching and medical advice given to the individual in the clinic or private office all too frequently are futile because they are not given in the full light of the family and home situation. The whole home itself whether adequate or inadequate as an environment for health is a family more than an individual concern. Recognition in public health practice of these facts is essential if the maintenance of health is to be the concern of public health activities."*

IF THESE CONCEPTS are valid—and we do not mean to imply that they are all-inclusive—we question the adequacy of health education, institutionalization, specialization, and fragmentation to meet the whole need. Indeed, if public health evolves along the lines indicated by Dr. Mountin, we see greatly increased need for something more. We believe there must be an agent (and why not the public health nurse?) who will attempt to relate the specialized and fragmented treatment of the individual to his life as a whole and to his membership in a family and a community; to understand the emotional springs of his behavior; and with this understanding to help him with the hard job of motivation and adjustment.

We doubt both the probability and the feasibility of the full accomplishment of these efforts by the "better general hospitals," though happily some progress in this direction is being made.

While we agree with Dr. Mountin's idea that more instruction should be given by the physician and nurse in the hospital, any great achievement along this line seems unlikely

*Burritt, Bailey B. More Adequate Provision and Better Integration of Community Facilities," The Milbank Memorial Fund Quarterly, January 1945, p. 28.

for some time to come. In the first place, hospital staffs—both medical and nursing—would have to be augmented to a marked degree if health teaching were to be universally included in the program. One questions how many hospital boards and administrators could be convinced that the added expense was warranted. In the second place, our experience leads us to think that with some exceptions, notably among the pediatricians, those who are surrounded by the acutely ill and immersed in their care are not, in the nature of things, free to give much thought to the less immediate health needs of their patients. More nurses with public health nursing background on hospital staffs, particularly in clinics, would help, and would certainly be desirable in any case. More interchange of nurses—and therefore of ideas and attitudes—between hospital and public health nursing services, would be mutually helpful. We are glad that instruction of the patient in the hospital is increasing, and with it a keener appreciation of the fact that satisfaction of the patient's needs often depends on his family setting. Even so, does not all public health nursing experience convince us that many patients will, in addition, require individual instruction and demonstration adapted to their own milieu and family understanding?

Dr. Mountin does not mention two large areas of public health nursing service, namely—prenatal nursing and child health service. Perhaps none of our work is of greater health and social significance; surely none calls more loudly for individualized teaching and guidance in the family circle. Popular instruction and group teaching in these subjects have their place and are unquestionably helpful, but to be effectual the knowledge gained must be woven into the daily life of the individual. Particularly where emotions are involved, such adaptations can be hoped for in many cases only if some skilled, trained person with insight, imagination, and patience can sit down to consider carefully the individual situation.

Side by side with the traditional service rendered by the physician and nurse in the child health conference, there is the need for more detailed help to be given in the nurses' visits to the children's homes. Obviously, many factors in the home influence the effective carrying out of instructions. Costs must be kept down. Ways of doing things with the equipment on hand must be worked out. Skill in their performance must be developed. Time for caring for the child must be fitted into the daily schedule without neglecting other members of the family. Parents must learn to know when things are going well with the child and when not. Out of her knowledge and experience, the nurse can do much to smooth the way for the mother and to give her confidence as she is gaining skill and better understanding.

THE CARE OF THE CHILD used to be thought of largely in terms of his bodily needs. Now it is recognized that his feelings have much to do with the functioning of his body, and that physical and mental health are inseparable. As it is chiefly through the giving of physical care that emotional attitudes are communicated to the baby, the nurse in demonstrating physical care may help in working out ways of doing things that lessen tension and produce ease in the mother. This in turn will elicit a happier response from the infant. Moreover, many parents welcome more explicit understanding of the maturation and personality development of their own child. They want to know more about the significance of daily experience—eating, sleeping, playing; about the normal sequences of growth; about the meaning of undesirable behavior and how to help him.

Dr. Grover Powers* has said that from one quarter to one third of all disorders bringing school children to the attention of pediatricians are "disorders of behavior and mental retardation," that "in many cases the physical evidences of disease (in school children) are but the somatic expression of psychic disfunction," and that "there are a host of organic diseases with psychic components." What causes psychic disfunction in children? Some of it, undoubtedly, comes from faulty handling of the child's feeding, for, according to Spock and Huschka,**

*Powers, Grover F., M.D. "School Health Problems as Seen in a Pediatric Clinic," PUBLIC HEALTH NURSING, January 1945, p. 7.

**Spock, Benjamin, M.D., and Huschka, Mabel, M.D. "The Psychological Aspects of Pediatric Practice." Reproduced through the courtesy of D. Appleton-Century Company, New York, 1938.

"Pediatric and psychiatric observation of children shows that when feeding has gone well it gives a basis for other life functions to do likewise. And when it has been unsatisfactory, the tendency is for the bad pattern to be passed on to other functions, infecting with a neurotic taint the child's subsequent attitudes toward bowel and urine control, toward sex, toward family, friends, and life pursuits." Some of it doubtless comes from the way his parents felt about the pregnancy, from the nature of their relationship, and from a thousand and one factors operating in the environment.

Visiting nurses are in a strategic position, because of their often intimate knowledge of the parents and their ready acceptance by them, to help lay the foundation of good physical and mental health. Also because of their excellent opportunities for observation, they can be most useful in foreseeing difficulties, or at least in discovering them in their incipiency, and, by working closely with obstetricians, pediatricians, psychiatrists, and social workers in helping to resolve them.

We might go on to elaborate on the "limitless possibilities for nurses" Dr. Mountin says are being opened up by "psychiatry in all its many aspects," but perhaps we have already said enough to indicate that our work must be infused throughout with the mental health concept.

And, too, much more might be said about the responsibilities logically devolving upon visiting nurse agencies in community plans for the care of the chronically ill; and of the many difficulties confronting the individual who may or may not wish or be able "to adopt without delay a regimen of life which will make possible the husbanding of his reserves."

ALL OF THIS demonstrates, to our satisfaction at least, the ever widening fields of usefulness open to the public health nurse if she cares to prepare herself professionally for work in them. And here we think is the crux of the matter. One reason why good friends like Dr. Mountin are not well informed about public health nursing, as we see it, undoubtedly is that we have not gone very far as yet in defining and developing the practice of public health nursing in a truly professional sense; in our courses too much of the emphasis has been on organization and administration—too little on individualized service.

Perhaps the fact that we must, and do, follow the physician's directions for the care of the ill patient has inhibited us in the free development of our distinctive functions. Certainly we have no desire to disturb this working relationship. However, we may well have been too modest in regard to the peculiar contribution of the nurse in the team, too slow in studying our own observations, and too hesitant in building up content for teaching based on our own seasoned experience.

The time has come—indeed is long overdue—for us to give much more serious thought to the analysis, synthesis, and interpretation of the fine art of public health nursing itself. Pioneering is going on in a number of places, but Dr. Mountin's article should force us to the more explicit formulation of means and ends. If we are to work with our patients in the round as personalities in families; if, recognizing the crucial importance of motivation and its deep-lying roots, we are to attempt to be helpful in guiding it; if we hope to be useful in allaying stresses and strains; if we think we should be helpful in guiding our patients to other agencies whose services they may need but are ignorant of or reluctant to seek; if we are to use the presenting need as a means of helping individuals and families to appreciate and attain their highest possible degree of physical and mental health—if these are some of the things we mean by the practice of public health nursing, then our general and professional education must equip us much better than it is now doing for these tasks. Furthermore, we must get on with the job of developing the necessary techniques.

On the basis of a much more thorough grounding in psychiatry, in psychosomatic medicine, in the dynamics of human behavior, in the growth and development of the child, in family and community life than most of us now have, we need to develop skill in: discriminating observation; analysis and recording; judgment as to what is possible for diverse personalities in diverse situations; recognition of the significance of the rela-

tionship developing between nurse and patient, nurse and person caring for patient, nurse and family; use of this insight in approach and in interviewing; helpfulness with long-term planning, especially in the care of the chronically ill and the tuberculous; understanding and working with other social agencies.

When we have done these things, we think we may be on our way toward meeting the challenge Dr. Mountin puts to us in his concluding paragraph:

"Finally, let there be no mistaking the fact that the influence of public health nurses on the total nursing force will be in direct proportion to the size and importance of that part of the whole nursing job for which they demonstrate special fitness. And even more specifically it will be determined by the continuing contributions they make to the body of technical knowledge and tradition, which, in the long run, forms the only justification for the existence of a distinct professional group."

NURSES IN WARTORN COUNTRIES IN DESPERATE NEED OF SUPPLIES

AN URGENT appeal for supplies for nurses in the war ravaged countries of Europe has been received from Mary Elizabeth Tennant, assistant director and nursing consultant, The Rockefeller Foundation, who is on an extended European tour. "Those of us at home," writes Miss Tennant, "who have been warm, well fed, and not in danger, have no idea of how awful this war has been." She asks that nurses in this country share the much needed items of clothing, stockings, food, and soap with their colleagues abroad.

Miss Tennant's plea is added to the appeals which have been coming to the International Council of Nurses for many months. Recent reports indicate that the number of nurses in need in European countries, China, and the Philippines, totals 650,000. The United Nations Relief and Rehabilitation Association as well as the national associations of nurses have already set up systems of providing the needed materials. The American Nurses' Association is conducting a drive for the collection of used uniforms, coats, shoes, et cetera. Shipments are planned soon to the national associations of nurses in four of the European countries. The Canadian Nurses Association has "adopted" the Dutch nurses, and has sent coats, capes, and food. The South African Nursing Association is collecting uniforms for shipment.

"Heartening and generous as the contributions have been," states Julia Freund in *The International Nursing Bulletin,* January 1946, "the enormity of the need which remains dwarfs the present accomplishment. Yet, the emergency can be met with just one gift from every nurse who is fortunate enough to live in comfort and comparative luxury measured by the conditions under which almost half of the nurses of the world are living and working."

To facilitate the collection of supplies, Miss Tennant has sent a list of names and addresses in five different countries to which packages (not to exceed 11 pounds) may be sent. She suggests that letters precede the parcels. The materials will be very much appreciated at their destinations and will be wisely and carefully distributed. These mailing addresses are:

1. Venny Snellman, Laakintohallitus, Helsinki, Finland

2. S. H. Hooykaas, Groenhoven Str. 1, The Hague, Holland

3. Agnes Rimestad, Director, School of Nursing, Ulleval Hospital, Oslo, Norway

4. Mlle. Cecile Mechelynck, Director, School of Nursing, St. Pierre Hospital, Brussels, Belgium

5. Wanda Lankajtes, Director, Bureau of Nursing, Ministry of Health, Warsaw; Jadwiga Romanowska, Director, School of Nursing, Danzig Academy of Medicine, Danzig; Anna Rydel, Director, School of Nursing, 23 Ul. Kopernika, Cracow—all Poland. Packages to Poland should be sent *to:* Foreign Service Mailing Room, State Department, Washington, D.C., *for* Donald Castleberry, American Red Cross Mission, care of American Embassy, Warsaw, Poland. The individual's name and address to whom the package is being sent should be written below Mr. Castleberry's address.

Addresses will be available later for Greece, Jugoslavia, and Czechoslovakia.

Through a foreign visitor to the NOPHN, the following address for packages to France has been obtained: Mlle. Liebermann, President, Association Assistantes Sociales, 3 Rue de Stockholm, Paris, France.

Nurse and Family In VD Control

By HAZEL SHORTAL, R.N.

PUBLIC HEALTH NURSING has made progress in the past decade in its approach to the problems of venereal diseases. Advantage has been taken of the many opportunities offered staff members to gain knowledge of the diseases—the causative organisms, mode of transmission, incubation periods, diagnostic criteria, pathogenesis of disease, treatment, and treatment outcomes. A much greater knowledge and understanding of human nature is necessary if we are really to accomplish our ultimate objective in venereal disease control.

The problems of venereal diseases as they affect the family can have intelligent solution only when those dealing with the situation know and understand the weaknesses and strengths of the individuals constituting families. The development of sane attitudes depends to a great extent on the appreciation of the normality of sex and the sanctions of sexual activity. The content of the home visit cannot be standardized. To do so would be to deny the patient the individualization which he or she deserves and to destroy initiative in the nurse. It is these underlying factors which must be understood in order that we may make our greatest contribution.

The following questions present themselves in any attempt to analyze the fundamental problems:

What are the contributory causes of venereal disease?
What are the factors in family and community life which make these diseases so widespread?
Where have we failed thus far in control?
What is to be the line of attack in the future?
And—what is to be the role of the public health nurse in this attack?

Let us consider the first question—what are the contributory causes of venereal diseases? The immediate cause is the organism of which we have already indicated knowledge. But to say that venereal disease is caused by the spirochete or the gonococcus is hardly sufficient answer to the question. Granted that the presence of the organism is a necessary preliminary to contraction of syphilis or gonorrhea—the question still remains: what were the circumstances in a particular patient's life which brought him or her to the state where he or she was willing to be exposed to such a disease? This is the efficient cause. Without such circumstance the immediate cause could hold no danger. Some say this efficient cause is a biological urge, or sexual desire.

Sexual desire is as necessary to insure sexual function as the hunger appetite is necessary to insure eating for bodily strength, and the sexual function was implanted in man to give him an incentive for sexual intercourse in order to insure propagation of the race. It is a normal function. Every normal person among us has a biological urge, yet some of us have learned to confine those biological urges to that state in life in which society has legitimatized such activity—namely, married life.

Wherein then does the problem of efficient cause lie? An answer to the question necessitates a study of the family and those sociological, environmental, moral, and ethical problems relating to family solidarity.

NURSE AND THE FAMILY

How can the nurse's influence in or with a family be a factor in venereal disease prevention? Untold opportunities exist for the nurse to give guidance to parents in helping the children to achieve high ideals in sex behavior. Childhood is the time in the life of any individual when real venereal disease prevention takes place. It is the opportune time for the nurse to begin her pro-

Miss Shortal is instructor of public health nursing at St. Louis University, St. Louis, Missouri.

gram for control. It requires that she be well informed in the principles of child psychology and that she apply these principles in giving instructions to parents.

Not only is her wise direction in the training of the children a contribution to prevention, but her able assistance in the solving of conflicts that arise from economic, religious, social, and sexual maladjustments of husband and wife tends to bring about the harmonious relationships necessary to prevent digressions from the normal union of married life. To be successful here the nurse needs to know and have an appreciation of family relationships and an ability to gain the confidence of her families in attempting to iron out difficulties. Here truly is her opportunity to utilize all the resources of the community for the promotion of physical and mental health.

That a happy home environment is essential in preventing venereal disease is evident from studies made of the home backgrounds of sexually promiscuous girls and women in various rapid treatment centers in the country. Lyon, Jambor, Corrigan, and Bradway in their recently published study of promiscuous girls in San Francisco state that family disorganization was characteristic in the case histories. Only 40 percent of their patients' parents were married and living together. In 287 promiscuous patients studied the age group ranged from 15 to 39 years with a median of 20.6. Of the girls 36 percent were single, 8 percent were living with their husbands, 19 percent reported their husbands absent, 23 percent were separated, 12 percent were divorced, 2 percent were widowed. Other studies have revealed similar findings. Some of these girls will undoubtedly find their way back into family life—some as wives and mothers; others, with the attainment of age and incapacitation, will attach themselves to some form of family life. It must be remembered that this represents an insignificant segment of our female population. The larger question of promiscuity among the military and those civilians who do not come to the attention of such clinics as offer reports of this kind must remain unanswered. Nevertheless these people and their promiscuity will have bearing on venereal disease as it affects family life in our coming generation. The stability of the family is vastly weakened by promiscuity and in many instances the assistance of the public health nurse will be sought in making adjustments. She must be ready and willing to help in a solution of the difficulties, recognize her limitations, and know what facilities the community offers.

NURSE AND SCHOOL

This quite naturally brings us to our second question—what are the factors in family and community life which make venereal diseases so widespread? Our educational systems in the past have been established to prepare young people for any and all professions in life with the exception of the one which is fundamental to the progress of society: namely, marriage and the family. As a result of this great lack many of our young people come to the married state completely unprepared psychologically and physically to accept their responsibilities. Where and how to bring this instruction into the school program has been a subject for much debate in the past few years. Some attempts have been made to give special courses in sex education. In the opinion of many authorities this tends to lend undue emphasis to the subject and may result in as much imbalance as did our former neglect. When possible a thoroughly integrated program which takes advantage of the many opportunities for giving information, interpretation, inspiration, and guidance would seem to eliminate this hazard.

It is not conceivable that every teacher in the school system is emotionally stable enough to handle the problems of sex in her daily class sessions. It is obvious that some classes lend themselves more readily than others to integration. It is important that the nurse working with teachers in the schools recognize these facts and, through expert guidance and consultation with teachers and principal, keep to a minimum the inherent dangers and develop as fully as possible the opportunities available.

Preparation for family life in high schools and colleges tends to reduce the misunderstandings and conflicts which may arise in homes. Unfortunately all young people do not have the benefit of this instruction. The public health nurse who can discern impend-

ing disaster due to maladjustments in married life and can guide her patients to a satisfactory adjustment is promoting family solidarity and preventing venereal disease. Recently a public health nurse observed some manifestation of psychoneurotic tendencies in a 23-year-old pregnant patient. Mutual exploration by the nurse and patient revealed this patient's lack of preparation for married life. So intense had become her resentment to her husband's sexual advances that she was considering separation. Deft handling on the part of the public health nurse prevented the breaking up of the marriage, but her efforts were too late to avoid syphilis in the husband.

Adjustments are always necessary in marriage. Alertness on the part of the public health nurse is required to discover inner pressures, anxieties, and confusions caused by the marital situation in the attitudes of either or both parties. Skill is needed in a reorientation of viewpoint and the retraining of destructive characteristics. The public health nurse may not have the time or be qualified adequately to handle such problems but a clear insight as to their nature can result in the utilization of community resources in order to prevent disintegration of the family.

NURSE AS CITIZEN

The elimination of those forces in the community which tend to promote promiscuity is not primarily a public health nursing responsibility but she can be of assistance as a civic leader by bringing to the attention of public spirited citizens the conditions which do exist. She can be of real assistance in the marshalling of church, civic clubs, and parents against such evil influences.

Wherever public health nurses have failed in venereal disease control, failure can be traced to an apathy or indifference on the part of the nurse. This apathy or indifference in most instances is due to a lack of knowledge or an unwillingness to accept venereal disease as a family problem. She is likely to think of venereal disease only as it is associated with vice. Whatever its cause, it is inconceivable that the public health nurse can cast aside her functions in communicable disease control.

What is to be the line of attack in the future? And what is to be the role of the public health nurse in this attack?

We public health nurses can review the progress of health promotion and disease prevention in many areas of health and sickness and feel very often with justification that we have been the "Messengers of Health" through which the local programs have attained success. Those of us who have observed various developments in public health have learned to accept increasing or waning enthusiasm on the part of the general public, according to the extent and severity of the problem at hand, the degree of opposition offered it, the sustained effort of the professional personnel involved, and last but probably most important the soundness of the program offered. In the areas of communicable disease control we have seen almost complete eradication of diphtheria and smallpox through immunization. In the field of tuberculosis control, health teaching has resulted in early case finding and voluntary isolation of the infectious patient and thereby a reduction in disease incidence.

Now we are in the midst of this, the venereal disease problem, and we find as we look about that far from our being the focal person in program activities, many other workers in related fields are giving equal if not more attention than we are to the problems of case finding and case holding. We are amazed at times at some of their methods. Good will come of these—at least immediate good. Public health nurses should be concerned about ultimate values and to these we must constantly direct our attention. The ambitious coworkers with whom we now join hands are of utmost service. At the same time to follow some of their suggested paths would be to subject ourselves to a repetition of errors which we have encountered in working out other problems. To bring the incidence of venereal diseases to an irreducible minimum is the common goal of all of us. Sane, safe methods are the surest means of attaining this objective. One has only to glance through the literature of a quarter of a century ago to observe that the venereal diseases presented much the same problems in World War I as they do now. If the problems were known 25 years ago, why haven't we accomplished the marked reduction of disease incidence so evident in other

communicable diseases? Can it be that the difficulties are insurmountable; that the venereal diseases are not preventable by means of early case finding and adequate treatment—the fundamental basis of our public health approach? Or, can it be that the spasmodic interest in venereal disease prevention found in time of war is a form of hysteria from which the majority recover along with the return of peace? Certainly to expect that the same intensity of effort will be maintained now that the stimulus of the emergency no longer exists is to be, perhaps, over-optimistic. In the quiet that is to follow the storm how can public health nurses do their part in holding the ground gained and continuing the advances now in evidence? For it would seem that, case finding and case holding being major responsibilities of the public health nurse, it will be upon her that sustained interest and continued success will in large measure depend. Sound procedures must be the basis of the foundation upon which we continue the attack.

CASE FINDING

If we are to find venereal disease and help the diagnosed patients to accept satisfactory treatment regimes, critical analysis of the methods employed is vital to success. We must proceed with an intelligent understanding of the basic considerations mentioned above and a discriminating evaluation of significant facts pertinent to a given situation. Techniques now in use have good and bad points. Let us be constantly on the alert to retain the good and discard the bad. It is important to remember that the patient is the key person in the venereal disease control program. No one wants to have venereal disease and having it he is not desirous of spreading it to others. The average person infected with venereal disease is grateful for the opportunity for cure if barriers real or imagined are removed. When such barriers are not removed the patient is likely to avoid medical and nursing assistance when he needs them most. His cooperation cannot be expected if he is uninformed or ill informed. Risk of job loss and fear of ostracism by his fellow men are sufficient reasons for any man who suspects that he has venereal disease to keep his suspicions to himself.

The whole question of case finding and case holding resolves itself therefore about the methods employed to uncover disease and the treatment routines established for those found infected. Probably no one procedure is adequate. Perhaps some are not appropriate in a given situation. The public health nurse who knows her community, the mores of the people, and their attitudes toward health programs in general will utilize whatever techniques of case finding and case holding are most advisable in her own situation.

Case finding is not new to public health nurses. They have engaged in this activity since the beginning. The question in venereal disease is simply one of knowing the methods of exposure, recognizing the possibilities of disease contraction, and maintaining a wholesome objective attitude toward the person exposed. What is to be the approach in making a visit to a named contact or patient? The answer is not simple. The circumstances surrounding any particular case calls for ingenuity on the part of the nurse. Who among you feel that you would expect to follow the same procedure in approaching a 16-year-old girl and an older known promiscuous woman; or the 20-year-old single boy and the 40-year-old man named by his wife's girl friend as her sexual contact?

There are a few basic considerations in making the first visit which may be mentioned here. Desirable are: (1) a thorough study of the information available in the nursing office, including not only the individual record but data regarding the neighborhood and the trends in promiscuity in the area as indicated by the prevalence of venereal disease and the rate of illegitimacy, (2) a personal interview with the patient if possible, (3) knowledge of facilities in the community for meeting the prospective patient's needs. Would you invite one of the clerks in the county court house to report during a regular clinic session to a treatment center in the same building? Because of the moral and social implications in venereal disease it is necessary to offer the patient sufficient privacy in order to gain and maintain his cooperation. In the friendliness of the city rooming house as well as in rural neighborliness the nurse meets obstacles in

maintaining this privacy. Letters of appointment for interviews either at home or in the nurse's office may avoid embarrassment for both nurse and patient.

CASE HOLDING

In discussing case holding or follow up in venereal disease it might be well to consider what is meant by the term. Many public health nurses would tell us that it means visiting the home or making contact with the patient: (1) to learn the home situation (2) to give the patient an understanding of the need for medical supervision to effect a cure, and (3) to arrange for contact examination. If the patient was the only one involved in regularity of treatment and venereal disease was the only illness which could affect the individual and he was an isolated entity, the above definition would seem sufficient. Such is not the case, however. What is involved in regularity or treatment? This is a responsibility which rests as heavily on the clinic personnel as it does on the individual patient. True enough the patient benefits. And so does the nurse. She is charged with the immense task of reducing and eradicating venereal disease. If patients do not come to clinic she fails to attain her goal just as the patient fails in his effort at restoration to health.

In a study made of lapses in clinic attendance in a prominent and well conducted syphilis clinic 85 percent of the lapses could be charged to conditions inherent in the clinic program and in the clinic personnel's failure to understand patient reactions. In order of importance the reasons for lapse were given as unsuitability of clinic hours, financial difficulties, shortcomings of clinic personnel, and painful reactions to treatment. If this is true of the so-called "best" clinics, what of the other—the "lesser lights" in our greatly expanded program?

In a large urban section, under an "improved" program of care, approximately 400 of a total case load of 800 early infectious syphilis patients lapsing in one month gave as their reasons, "They jabbed my arm three or four times before they hit the vein," "The needle was so dull it felt like they were tearing my skin," "The nurse was cross with me," "I wanted to go on the same day as my friend but they wouldn't let me change." Four hundred unnecessary interruptions in treatment. Four hundred unnecessary follow-up efforts, either written messages, or nursing visits to the home. At the rate of the estimated average cost per nursing visit in the home and the present nursing shortage this seems to be an extravagant waste of vital personnel. Follow up, therefore, should begin in the clinic itself. Continuous evaluation of the service rendered in the clinic and constant alertness to faulty equipment and technique are the first steps in follow up.

Too often in the care of the venereal disease patient we tend to think of him as one not subject to other ailments or common human needs, as evidenced by the following excerpt from an actual interview between patient and nurse:

NURSE: Robert, you must take your treatments regularly if you hope to get well.

PATIENT: Yes'm, I'd sure like to but I have to go for my refills every other week on Thursday.

NURSE: Well, Doctor told you how important it is for you to get your treatment for syphilis. Remember syphilis can do you just as much harm as tuberculosis. You will have to figure out a way of getting your treatment regularly.

Would that the nurse had seen equal possibilities of the harm resulting from neglect of the tuberculous condition. Helping the patient to a solution of his problems then would have avoided a home visit five weeks later when, following discomfort in the chest as the result of a re-expanding lung, the patient lapsed from the syphilis clinic to get his needed refill. A physician in one of the small health departments of the country assumed the responsibility of follow up of all primary and secondary syphilis cases in his community. His procedure after diagnosing the patient was to inform him that if he missed one treatment, the nurse would "look him up," but there would be no second visits from the health department. If he missed a second treatment, the police would pick him up. Is it any wonder that when interviewed for contacts the patients gave either no information or misinformation, or named only those contacts against whom they harboured resentment?

Follow up entails an appreciation of the patient's problems on the part of all personnel and must be a part of every contact with

the patient. Good follow up in venereal disease requires consideration of the total health and personal needs of all such patients.

How much follow up should be done is again a question of the individual case. It depends on the infectiousness of the case, the amount of treatment already received, the willingness of the patient to protect others through limitations of his own conduct, and the possibility of eliminating the obstacles that stand in the way of treatment. Is there any reason to visit the patient who is receiving treatment regularly and who apparently is following instructions regarding personal hygiene? Would you consider it wise to use public health nursing time visiting the head of a household whose working hours conflicted with the hours of the clinic? Or would you give preference to a syphilis visit over that of a new diphtheria case?

Probably the best help to give a delinquent patient is to remove those obstacles which prevent regularity of treatment. Then further effort will depend on those factors mentioned previously,—infectiousness and his admitted promiscuity, plus the policies established by the particular department employing the nurse.

IMPULSION VERSUS COMPULSION

In no phase of communicable disease has it ever been possible to bring all infected and exposed persons under adequate medical and nursing supervision. Yet through employment of democratic methods it has been possible to reduce considerably disease incidence. Unfortunately, we find much evidence of compulsion in the treatment accorded venereal disease contacts and patients. It is true that most health laws and regulations provide for forcible means of isolating the patient who can be proved a menace to the health of others in the community. When is the syphilis or the gonorrhea patient a menace to others? Are we always sure that such is actually the case in planning enforced isolation of the patient? Or is it not sometimes an opportunity for the official agency to assert authority—a desire to demand respect for the formula we think right? Is it a way of imposing health on people? Many will recall this statement by Surgeon General Thomas Parran:

> If we aspire toward the concept of positive health, it is clear that the most important factors in the objective are to be attained by impulsion rather than by compulsion. Authority to check the spread of communicable disease must be complemented by the spontaneous desire to use science as fully as possible in order to build one's individual strength. The saving health must be earned by the individual and by the nation. It cannot be bestowed as a free gift by the most benevolent dictator. It cannot be thrust upon a population by mandate. The attainment of health, as the attainment of the capacity for self-government, requires the democratic method of education, wise leadership, and voluntary cooperation, with arbitrary control of the individual only where the good of his fellow countrymen demands it.

As Dr. Parran says, education is the means by which we must expect to find cases and hold cases in all phases of public health. Giving the patient an appreciation of his needs and the possibilities of benefits to be derived from health supervision are the tools the nurse must continue to use if she wishes to impel or motivate the patient to seek and continue medical care. Education will not bring all venereal disease patients to medical supervision. Neither has it always brought other patients to adequate care, but it is a goal toward which all can work.

SUMMARY

In summary, venereal disease prevention and control presents one of the most challenging issues in public health today. As in all other areas of disease in which the public health nurse functions, the approach must be on the basis of family health, immediate or remote. Teaching must be on the basis of recognized individual needs in the home, school, and clinic. This implies a background of knowledge regarding the diseases and an appreciation of the resultant social and emotional conflicts in the individual and the family. The nurse who is finding her efforts fruitless must critically analyze her methods. When the program is non-effective a study of possible reasons should be made. Are the clinic hours established for the convenience of patients or personnel? Are the patients treated in a manner becoming the dignity of human beings? Is the patient the focus of attention? Does the attitude of every member of the staff tend to promote or retard good rapport?

The following questions are proposed as an examination of the nurse's own attitudes:

Can I be unemotional in discussing sex?
Do I ask questions in a manner that implies guilt to the patient?
Do I keep direct questioning to a minimum?
What techniques do I employ to help the patient to self-expression?
Does my manner indicate a hurried, indifferent, admonishing attitude toward the patient's problems?

Public health nurses have never failed in an assigned task. They must not, they cannot fail now. Those who have succeeded in their individual efforts must serve as leaders in bringing about the united effort of all public health workers in the prevention and control of the venereal diseases.

This paper was read at the Public Health Nurse Section meeting of the Michigan Public Health meeting at Grand Rapids, Michigan, November 8, 1945.

BIBLIOGRAPHY

Gruenberg, B. C. and Kaukonen, J. L. High Schools and Sex Education. U. S. Public Health Service, Washington, D. C., 1939.

Lion, E. G., Jambor, H. M., Corrigan, H. G., and Bradway, K. P. An Experiment in the Psychiatric Treatment of Promiscuous Girls. U. S. Public Health Service, Washington, D. C., 1945.

Parran, Thomas. "Saving Health Among All Nations." *Survey Graphic,* March 1942, p. 151.

Rose, E. J. Fundamental Sociology. Bruce Publishing Company, Milwaukee, 1942.

Social Hygiene Day

(Continued from page 50)

Dr. John H. Stokes, in his address before the New York Regional Social Hygiene Conference on February 6, discussed the reasons why we are forced to admit that this is still an unsolved problem. Citizens and public health workers alike may well ponder the six forgotten elements which Dr. Stokes outlined for consideration in talking about its solution, and fix their own responsibility for things done badly, or not at all. He said:

We have never studied through to the fundamentals of the problem. We have never taken it apart and really analyzed it.

We have been content to accept fractional programs, solving only parts of the problem.

We have thought of medical treatment of the venereal diseases as the answer and way of eliminating the whole problem. But new infections continue to increase.

We have educated the people too little and too late. Standards of teaching social hygiene have been questionable. There has been too much argument about method and form instead of making forthright attacks on the whole problem of human behavior.

There has been a let-down on the moral and morale front. We must consider the changing standards of our populations and recognize the inadequacy of our character agencies to reverse the trends.

And most of all we have forgotten the nature of man. Man himself is basically a dignified, intelligent creature endowed with at least some of the attributes of deity. Comprehension of this dignity and these attributes must be reestablished in the lives of mankind.

Hazel Shortal, in this issue, suggests ways by which we can study through some of these fundamentals. The report of the USPHS Advisory Committee on Public Education for the Prevention of Venereal Diseases, summarized on page 99, offers other suggestions.

Public health nursing agencies may well take stock of the effectiveness of the venereal disease service in their programs. Are they doing all they can, are they doing it as well as the best experience has shown is possible? Recent figures collected by the NOPHN Statistical Department indicate wide variations between agencies in the volume of this service. Sixty-eight percent of nonofficial agencies, 33 percent of municipal health departments, and 7 percent of county health departments reported no public health nursing visits for venereal disease service. In these communities do the figures mean that some other agency, or perhaps personnel other than nurses, were performing this service, or was there a need unmet by any means?

These and many other questions must have an answer if the nation is to fulfill this, our most difficult mission in public health.

Looking at Industrial Nursing

By ALICE HAMILTON, M.D.

MY ENTRANCE into the field of industrial medicine occurred in 1910, and as I look back I can see no picture of a well equipped plant dispensary presided over by a white garbed, authoritative, competent nurse. What memory brings back is a first-aid room, sometimes clean and orderly, sometimes appalling, under the charge of a foreman, with a doctor "on call." Serious cases went to the nearest hospital. The largest concern I visited in 1911, employing thousands in heavy and hazardous work, depended on an old Civil War veteran doctor whose office was his front parlor and whose wife acted as nurse-assistant in emergency cases. Mrs. Bethel McGrath* tells us that the Proctors of Vermont were the first to employ an industrial nurse, in 1895; that John Wanamaker in New York and Frederick Loeser in Brooklyn had followed suit by the end of the century and some ten other firms by 1906. But most of these were department stores, not lead smelters or copper mines or white lead works, and so I did not see them.

Then in 1911 the states began to pass laws compensating for industrial accidents (occupational diseases were not covered until later) and this gave great impetus to all sorts of methods for the prevention of injury to workers, including the installation of plant dispensaries and the employment of trained nurses. In those days I would often find a nurse in full charge, not only of first aid to the injured and of the important decision as to the seriousness of the injury and the need of summoning a doctor, but also of the selection of workers for strenuous or dangerous jobs and of all the measures to be taken for prevention of injury. I remember a large rubber factory which, as was customary in 1915, was using large quantities of aniline oil in compounding rubber. I told the manager that I was looking for cases of anilinism and he at once sent for the nurse. "She is the only one who knows about it," he said. "She discovered it and she knows where the men get it."

The great changes that have taken place in this field show the effect of the passage of workmen's compensation laws, of the sudden increase in Labor's importance during the first World War, and of the subsequent business boom and depression. By 1918 some 1,213 nurses were working in industry; in 1930 there were 3,189; but with the depression of the 30's the number dropped way down. However, nurses fared better than did industrial physicians. When faced with the necessity of cutting expenses to the bone, many an employer let the doctor go but kept at least one nurse. I can testify to the amazing competence of many a nurse who had to carry on as virtually the head of the medical department and this at a time when the serious illness of a wage earner was a major disaster to his family. At present, under the impetus of World War II, the number of industrial nurses has risen to 12,838. Will this figure also drop in a second postwar depression?

One gains from Mrs. McGrath's book a picture of great progress in industrial preventive medicine, not only in the medical department itself but in all departments that have an indirect influence on the health of workers. The word, "welfare," which she uses quite boldly, still gives me a sense of repulsion, though I realize that it is now a reformed character. I remember that when I was in England in 1919, visiting felt-hat

Dr. Hamilton, pioneer in industrial medicine, has been professor emeritus of Harvard since 1935. Now retired, Dr. Hamilton resides in Hadlyme, Conn.

*McGrath, Bethel. Nursing in Commerce and Industry. Commonwealth Fund, New York, 1946.

and storage-battery plants (the English call them electric accumulators), one of my guides asked me about welfare work in the United States. I told him we never used the word because it had been completely discredited, especially by one great nationwide company which had used it to cover up espionage and blacklisting. It is good to know that that memory has faded and the word again has its real meaning. Mrs. McGrath uses it to cover many activities within industry, some paternalistic, some under employee management, as well as the work of public health services, loan associations, and credit unions. Incidentally, she urges the nurse to study the last two so that she can give advice that may save the worker from trusting the untrustworthy.

THE FIELD of the industrial nurse may seem to have narrowed in late years as the system has improved and the number of industrial physicians has increased, but actually it remains both wide and complicated. No one knows as well as the nurse the danger points in the plant. The first sickness map of a plant I ever saw, with colored pins to show where sick workers had come from, was in a nurse's office. Obviously she was the one who knew best where lead fumes were escaping, where the exhaust system over a degreasing tank was faulty, where there was an epidemic of infectious sore throat. The nurse can also, better than anyone else, observe the effect of the subtler dangers that do not cause definite disease but break down health, such as cumulative fatigue, both physical and emotional. I am glad Mrs. McGrath has stressed the danger of speeding up, for it is to my mind the greatest evil in modern industry and the hardest to control. Again and again I have stood in a model factory room, light, clean, airy, pleasant, and watched men and women working at an uninterrupted speed that I knew could not fail to produce excessive fatigue, only partly muscular, more largely the result of irritated nerves.

Many passages in this book deal with activities that are taken for granted in modern industry but to me still seem revolutionary: not only pre-employment examination of workers but periodic medical check-up and check-up after absence; the large part played by the personnel service; the effort to find employment for the handicapped instead of consigning them to the scrap heap; the attitude of condemnation toward undue labor turnover. In the early days that I can remember, humane foremen in the great lead smelters and white-lead works encouraged rapid turnover, hoping thus to prevent their men from getting too deeply "leaded." Another excellent advance that has been made—though I fear not as yet universally—is the abandonment of the policy of secrecy about dangerous jobs and the adoption of that of frank instruction on how to prevent injury. Time was when the industrial nurse dared not tell a sick worker the nature of his illness if it was caused by fumes or dust or gases. Now it seems she is expected to tell him just what danger he is exposed to and what symptoms to look for.

BUT TO MY MIND the nurse's job, though improved in many such respects, is in other ways more complicated than when she was working under pioneer conditions which were difficult but fairly simple. She now must tread warily the path between the workers, organized and feeling their new power, and the employers, well meaning usually but with little or no insight into the psychology of the workers. And she must do this without arousing suspicion that she is on the side either of the employers or of the workers. She must recognize the fact that management's first interest is production and the worker's is his job, his hours, and his wages, but she must be careful not to let herself be used to advance production at the expense of the worker or to put the worker's job ahead of his health. A man who has early silicosis or an enlarged heart may cling passionately to his dusty or overstrenuous job, but the nurse must not yield. The foreman may plead for the early return of an essential worker or for the discharge, on a faked-up diagnosis, of a troublemaker, but again the nurse must not yield. The very fact that the nurse is the one person to whom the employee feels he can talk freely brings all sorts of problems to her, for she comes to know the plant and all the inhabitants therein as no one else does. Even when she is powerless to bring about the reforms she knows should be made she can comfort her-

self with the thought that merely listening to an aggrieved worker has helped him to "cleanse the stuffed bosom of perilous stuff." Mrs. McGrath makes this very clear in her admirable chapter on mental hygiene.

During the 20's the Western Electric Company instituted a system in its Hawthorne (Chicago) plant under Lawrence Henderson and Elton Mayo of Harvard that demonstrated clearly the emotional source of much industrial fatigue, poor production, and labor unrest. They found that hours and wages played a less important part than emotional factors. Their conclusions were based largely on the improvement that followed when workers were induced to pour out their grievances to a listener they could trust, for the mere act of getting a complaint off one's chest lessens the sense of frustration and anger. I talked it over with one of the executives of this huge plant and he told me that he and his colleagues had expected that the complaints turned over to them by the interviewers would be unreasonable, frivolous, stupid, but not one was completely without justification and most were of real value to management.

Several parts of this book I should like to commend with special enthusiasm. One is the section treating of my own specialty, industrial poisons. It is clear, accurate, concise, has no extra verbiage, is not repetitious of generalities that only clutter up—and that are so often found in books of this sort. Another is the fair, judicious, yet sympathetic treatment of malingering and of trade unions, two subjects that few writers succeed in presenting with true impartiality.

This book is not only for nurses, it is for the general public. It should lead to a new and well deserved appreciation of the work of this important group of women. As a closing tribute to them, I should like to say that I have met a number of industrial doctors who were devoted to the interests of their employers to the point of indifference to the welfare of the workers, but I have met only one industrial nurse of whom that could be said.

This article was written by Dr. Hamilton as an Introduction to *Nursing in Commerce and Industry* by Mrs. Bethel McGrath, now in press. It is reprinted here with the permission of the author.

Amendment to G.I. Bill

ENACTMENT into law on December 28, 1945, of H.R. 3749, an amendment to the Servicemen's Readjustment Act (G.I. Bill of Rights), brings about important changes in the educational benefits referred to in "Some Interpretation of Educational Benefits," PUBLIC HEALTH NURSING, December 1945, p. 628.

Revisions in the Bill of greatest significance to nurses are the following:

1. Elimination of age restriction and requirement that veteran prove his education has been interfered with because of his service. All eligible veterans now are entitled to education or training for 1 year plus the time in active service after September 16, 1940.

2. Increase in subsistence allowances from $50 to $65 in cases of veterans without dependents, and from $75 to $90 in cases of those with dependents.

3. Extension of time in which a veteran may initiate a course from 2 to 4 years after his discharge or the official termination of the war—whichever is later, and extension of time within which education or training may be afforded from 7 to 9 years after termination of the war.

4. Authorization of short intensive training courses and correspondence courses in approved institutions, if annual cost does not exceed $500. Removal of distinction made in the old law between refresher or retraining courses and education or training.

There are also significant changes in other provisons, such as those for vocational rehabilitation, loans for homes, farms, and business purposes. Issue No. 49 of *Child Welfare Information Service, Inc.*, December 26, 1945, summarizes these. For a copy of "The Amended GI Bill of Rights and How it Works," write *Army Times*, 1419 Irving Street, N.W., Washington 10, D.C.

School Health: Whose Job Is It?

By CHARLES E. BRAKE

WHENEVER educators have stated the objectives of free public school education, they have placed health at the head of the list. That priority has never been successfully challenged by other interest or pressure groups.

A statement of objectives, like a statutory provision, however, is but a "tinkling cymbal" if those in positions of responsibility for educational curricula and procedures have not the vision and the courage, particularly the latter, to make good on the statement. A casual visit to any one of thousands of classrooms throughout the nation might reveal the following conditions. Miss X, a middleaged lady, is "hearing" a class in health. The sun has not shone all day but the upper half of each window is covered by the shade, while across the lower half is hung a curtain for the ostensible purpose of beautifying the room and making for a homelike atmosphere. A thermometer, placed at a height of six feet from the floor (so teacher can read it with perfect ease), registers 80°. The teacher has been teaching health all morning and just hasn't had the time to adjust shades and check the thermometer.

Miss X looks a little pale, is underweight and highly nervous. This, she explains, is due to the "hornery brats" she has to teach. They don't want to learn. She has read somewhere that teachers should have physical examinations but she has been too busy, what with teaching during the regular school year and going to school summers to work on her degree. When she gets that degree then she is going to look after her health.

Noon recess comes and the children rush to the school yard to eat their cold lunches "fished out" of paper bags with unwashed hands. With ten bites, six gulps, and a holler, they are ready for an hour of baseball, tag, or what have you.

Every four or six weeks each child receives a report card and down in the lower ranges of the assorted subjects appears the word "health." If a child has learned the material in the textbook well, he may receive an "A" or a "B" in health although he may be the very picture of unhealth.

I have dwelt at some length on the above situation because it emphasizes the absolute necessity of making health education functional if the objectives so nobly set are to be reached even in part. True, in many instances, schools and other agencies are doing a very commendable job in caring for the health of school children. But, in all too many cases, we are doing little except paying lip service to a noble experiment.

Since statistics reveal that of those rejected for military service for physical reasons, approximately 85 percent could have been made eligible through early correction of defects, it is apparent that the task ahead in the field of health is a tremendous challenge.

A consideration of the health protection of all school children of any community or area should include a study of all factors that affect the health of all of the people of the area. These factors are sanitation, control of communicable disease, housing, hospitalization, and the rest.

THE ONLY program that can hope to succeed in dealing with all of these factors is a cooperative program. Cooperation must be had not only in executing the program but in planning and appraising the program as well. The school is but one agency and must work with all other agencies in the field of health education and protection.

To hold that all health education must be done by teachers and all health service rendered by doctors and nurses greatly over-

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simplifies the problem. Any capable, well trained nurse who enters a home for health service of almost any nature whatever does some work in health education. For instance, showing a young mother how to bathe her baby is health education. By the same token, if a teacher renders first aid to a boy who has slipped on the ice and fallen, she is rendering health service. To attempt to define the jobs of the school and the public health department too closely and to draw a line of demarcation between the teacher and the service agent of the public health department undermines the very foundation of a cooperative program. It is better to do than to find hairline reasons for not doing.

Cooperation depends much more upon attitudes than upon delineation of functions. To secure and maintain proper attitudes requires the services of a tactful, understanding coordinator. Without such services, minor differences tend to be magnified, professional pride is hurt, and a little ditch becomes a great chasm.

Wayne County, Michigan, is in the early stages of development of a cooperative program. Following the first world war, a staff of nurses was attached to the office of the county superintendent of schools and worked under the direction of that official. Their work was confined almost entirely to health protection of school children in the rural schools.

In April 1943 a health unit was established in Wayne County with a Board of Health consisting of five members. Gradually, the nurses on the staff of the county superintendent of schools came under the direction and supervision of the director of the public health unit, with the head nurse of the school's staff becoming supervisor of all of the nurses of the health unit. One nurse, however, is retained on the staff of the county superintendent of schools and she is designated as the coordinator. Her time is divided between the two departments and she has office space in each.

The curriculum in health instruction, including choice of books and other health materials, is planned cooperatively by the supervising teachers, visiting teachers, nurses, sanitarians, and department heads. This curriculum is interpreted to include health examinations, immunization, weighing, measuring, handwashing, hair combing, fingernail excavation, and other activities, as well as teaching. The aim is to get action on the basis of knowledge rather than to build up knowledge for knowledge's sake.

UNDER THE cooperative program, the employees of the health unit, including nurses, sanitarians, and health educators, offer a generalized service instead of a service limited to schools. In this way a much more adequate coverage is given because school health is but one phase of the total community health protection program.

The place of the teacher becomes one of significant importance under the cooperative schedule. She, of necessity, must become health conscious. A physical examination at least once each year is as essential as her three meals a day. Environmental health also takes on a new importance. Heat, light, water, sewage, screening against flies, and humidity begin to have meaning in terms of the health or unhealth of children. The teacher sees the need for action and usually acts. Likewise, when the doctor and nurse visit the room for examination or other service, the teacher, fully informed well in advance, has the stage all set. With the assistance of the two health officers of the Citizens Junior Club of her room, space has been prepared, with sheets hung and utensils provided. If immunization is to be provided, parental consent has been secured by the teacher and the children have studied the meaning of, reasons for, and technique of the immunization process. A natural learning situation has presented itself and the teacher has taken advantage of it.

The doctor and nurse, likewise, have a definite responsibility in this phase of the cooperative program. A time schedule must be set and adhered to rigidly. Consideration for the teaching schedule of the teacher must be given. The act of immunization can also be a learning situation for the children and the wise doctor and sympathetic nurse can and do take advantage of it.

The supervising teachers, since they work with all the teachers, can and do assist in stimulating, motivating, appraising, and rethinking the whole health program. Often throughout the school year the supervising teacher and nurse confer with an individual teacher regarding the health program in a particular school situation. As a result of these

conferences, the program becomes more meaningful and purposeful.

The visiting teachers, who work with individual children who give evidence of a lack of proper adjustment in school, find many occasions for conference with the classroom teacher, the nurse, and the parent in assisting children to readjust. Too often, the basic reason for maladjustment is unhealth, physical or mental, or both. In no instance can the visiting teacher do a capable job of rehabilitation without enlisting the aid of all those who work with the child in the school and in the home.

The aims of the total school health program might be stated as follows:

1. To encourage parents to prepare children physically for entrance to school
2. To prevent and control communicable diseases
3. To detect physical abnormalities and encourage correction
4. To encourage immunization and vaccination
5. To recommend and encourage physical examination of teachers and other school personnel
6. To create proper health attitudes among school children, teachers, and parents, and to interpret the health program to teachers, school boards, and the communities
7. To make health teaching functional
8. To encourage and promote the importance of safety education

CERTAIN helpful attitudes toward other school activities naturally result from the prosecution of these aims. The hot lunch program of the school, for instance, becomes a means of promoting health instead of providing a convenience. The nutritionist from the health unit, the teachers, and the cooks work cooperatively to provide the most nutritious lunch possible under the circumstances. Quality and nutritional value become criteria more important than quantity.

The scheduling of classes in terms of energy level of children instead of administrative expediency fostered under the cooperative program tends to prevent schedules which interfere with the health of the children. The above also applies to bus schedules and lunch schedules. Provision of work experience, either within or without the scheduled school day, is likewise evaluated in terms of health needs of the individual child.

Recreation, physical or mental, under the cooperative program must be planned in terms of health needs, and a really effective school recreation program cannot disregard all other recreation of children, scheduled or unscheduled. The quarrel over whose responsibility recreation is seems pointless when one realizes that all agencies—school, church, home, and community—have responsibilities in this area. Again on a cooperative basis, that recreation can be provided if certain vested interests can be moved or circumvented. In any instance the health unit plays a definite part in setting up the program.

The bane of the average teacher is record-keeping. Nevertheless, health records must be kept and the teacher is in the best position to keep them. In addition to the records of children as individuals, the teacher should pass on to her successor a rather carefully prepared outline of the health experiences of the children as a group to make for a more adequate synthesis of curriculum effort.

Integration is the keynote in the success of a school health program. Whose job is school health? Cooperation based on proper attitudes makes the individual responsibility a unit of the joint responsibility. Duplication is eliminated. A healthy child in a healthful environment is the sole aim.

Public Health Nurse in the Rural School

By MARGARET MAXWELL, R.N.

HOW CAN school nursing be included in a one-nurse generalized county public health nursing service if there are from 75 to 135 one-room schools plus the town and parochial schools to be served in the county?

When nursing services were first started in this area five years ago, institution of a generalized nursing service was not easy. The popular conception of the activities of a public health nurse was that she served only the schools. Employing boards held the same idea which made the struggle even more difficult. The people wanted the nurse to visit each school and do inspections of each child each year. Any attempt to show that this type of service had proved a poor expenditure of nursing time elsewhere proved futile.

The only thing to do until the services were established was to go along for a while and do what the people wanted. It was impossible to get into every school each year but as many were visited as was possible. The result was that most of the nurse's time was spent in school work. By so doing, a program was being carried on which the people understood and they accepted nursing services on this basis. Gradually, it seemed that adjustments could be made in the school program and new services added. This type of a school program was carried on for two years.

At the end of this period the time seemed opportune to demonstrate to employing boards, school superintendents, nursing councils, and interested lay groups that there were other worthwhile activities which public health nurses carry on and many other problems important to community health—problems of communicable disease control, mothers and babies, sick people, and crippled children. All of these needed nursing service. Annual reports, which were given wide publicity, pointed out the many services that nurses included in their programs.

Also, by this time, a few facts and figures had been compiled. The nurses in several counties under observation were finding the same apparent defects the second year as they found the first year. Corrections were not done because all their time was involved in doing "inspections." They had no time to visit the parents in connection with these defects. Parents were invited to the schools at the time of the inspections but so few came that there was very little contact in that way.

As other activities were included in the program, it was getting increasingly impossible to visit any large number of schools each year.

At a staff conference of the nurses in five counties in the Spring of 1942, the next move was discussed. It was decided that in order to make progress in solving this problem the help of the teachers would be needed. They could be taught how to do vision tests, weigh and measure, observe children for symptoms of communicable disease, collect samples of drinking water for analysis at the State Hygienic Laboratory, keep school health records for each child, and work on problems of sanitation.

The proposed plan was then discussed with the school superintendents. It was pointed out that each child would actually receive more service because the student would be getting the service throughout the year. The superintendents gave their approval to start. Throughout the remainder of the school year, the change in the school program was discussed with teachers and other interested people at every opportunity so that the way was paved for a beginning in the fall.

In order to put the plan into effect, the

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county public health nurses met with the teachers at their first county institute and explained the program. Then small meetings were arranged for teachers in one or two townships. Demonstrations were given of vision testing, weighing and measuring, making observations of pupils, collecting samples of the drinking water, and keeping the school health records. Recommendations were also made as to teachers discussing the conditions they found with the parents and interpreting the need for medical and dental care where it seemed necessary.

THE materials needed for the year were distributed. These were as follows:

A school health manual. The manual contained directions for the procedures the teacher would carry on. It also included information on the necessity of a healthy teacher; responsibilities of the teacher, nurse, and parent; planning a healthful school day; first aid; diphtheria immunization and smallpox vaccination programs; literature lists for health instruction; instructions for transferring health records when a child transfers to another school; and a section on sanitation. The State Department of Public Instruction cooperated by furnishing a Snellen symbol vision chart for each school. The manual was to be used throughout the year and then returned to the nurse at the end of the year.

Individual health records. A school child health record was provided by the Iowa State Department of Health. This was particularly adapted to the needs and ability of the teacher in making observations of health problems. One record was supplied for each child in the school. These records were kept in an envelope attached to the back cover of the manual. For a beginning, all of the nurse's records were turned over to the individual schools. These cards were also turned in at the end of the school year. In this way fewer records and manuals were lost.

Communicable disease wall chart. This chart contained a list of the common communicable diseases. The symptoms, modes of infection, and the regulations for the exclusion of the case and contacts from school was given for each. One chart was given each school. Teachers were instructed to follow the directions given when a communicable disease occurred. These were hung in a conspicuous place in the school. Some of the teachers have had them framed so that they remain clean.

Communicable disease survey form. One form was given for each new pupil. The parents were asked to list the diseases, operations, and the preventive treatments the child had had. Identifying information such as birth date and parent's name and address was also given. These were returned to the teacher who transferred the information to the school health record.

Enrollment of new pupil cards. The teacher listed the pupils for whom she had no card and returned it to the nurse. This would be a child entering school for the first time or it would be a child transferring from another school. If it was a transfer, the last school attended was listed. The card was obtained from that file and sent to the new school. Transfer cards plus new records for beginners were sent to the teacher.

Dental cards. One card for each pupil was supplied. The county or town superintendent purchased these. Each child participating took this card to his dentist and had an examination. The card was signed by the dentist when all necessary dental work was completed. The card was then returned to the teacher.

Report of vision testing. After the teacher had done the vision testing, she completed this form, designating the results of the testing and sent it to the nurse. Other apparent health problems were also listed.

These same forms are still being used. Minor changes are made when necessary. Schools now purchase the individual health records. It is only necessary to add these each year for the new pupils. Information on communicable disease history, operations, and immunizations is brought up to date each year.

AFTER THE NURSE received the vision test reports, visits to schools were planned. Basis for selection were those schools where more serious problems seemed to exist, where there were new teachers, and where the teacher seemed to need additional help in carrying on the program.

When the nurse visited the school, she

would review the individual health records and evaluate the content to determine further activity. If follow-up visits, where indicated, had not been made, she would suggest that the teacher do this. If the teacher had visited the family and was unsuccessful in obtaining results, the nurse would list the visit to be made while in the area. If the teacher needed additional help with any of the procedures, this would also be given. Details of sanitation and solution of any problems would be discussed. Needs for health education materials were studied and suggestions made as to where they might be obtained.

Teachers were invited to write, call, or visit the nurse's office to discuss special problems. Bulletins on various subjects were prepared and sent out during the year.

This program has been functioning three years now. The first year no study was made of the results. Studies were made, however, of the second and third years in this five-county area in northeast Iowa in which the program was being followed. Questionnaires were sent to all the schools. Some of the results brought out are as follows:

	1943-1944	1944-1945
Questionnaires sent to schools	490	476
Schools returning questionnaires	447	469
Schools having water supply tested	125	226
Schools having daily observations	357	376
Schools keeping health records	381	418
Schools weighing pupils	95	280
Schools measuring pupils	119	340
Schools doing vision testing	447	440
Children having unsatisfactory vision tests	596	517
Parents notified of result of vision tests by teacher	402	326
Children having eye examination by physician	397	231
Children receiving glasses or having lens changed	262	215

It is interesting to note in the year 1943-44 that 262 of the 397 children who had vision examinations by physicians needed correction. In other words, 66 percent of those who were referred by the teacher and had an examination by a physician actually had difficulty. The next year, 93 percent of those referred who had examination needed corrections. It would seem that the teachers are doing satisfactory tests.

In addition to this, all school records are reviewed as they are returned in the spring. The majority of these are well kept. It is very easy to get an accurate appraisal of each child by reading the records. If a home visit seems to be indicated during the summer, these are made by the nurse. The nurses report that the teachers have made excellent and useful observations of the students.

As plans for the future are being made, the time when it will be unnecessary for the nurses to visit many schools individually throughout the year seems to be arriving. One nurse has already eliminated much of this activity. Meetings are held with teachers in each township. Their problems are discussed together. The help they give each other by their experiences is gratifying. If they need help in carrying on any of the procedures, it is given at this time. Their individual health records are studied and suggestions made in keeping them if it is necessary. Follow up on any health problem is discussed. If it has not been done, the nurse and teacher plan for it. Visits to the schools in this county will be scheduled by the nurse only when some special problem seems to warrant it.

SINCE THIS program has been in effect three years, nurses and administrators believe that the problem of giving health service to schools has been solved. The following conclusions seem justified:

More complete and continuous health records of each child are being obtained since these are kept from the first through the eighth grade by the teachers.

Nurses have more time for family health service and they have more time for contact with school directors so that problems of sanitation can be attacked.

Teachers for the most part seem to be interested in the program, as is evidenced by their excellent cooperation. They feel more responsibility for a health program.

Generalization makes it much more possible for a public health nurse to give service in all of the areas needing her attention.

Parents are becoming more aware of the relationship between the work of the teacher and that of the nurse.

The facts and figures obtained from the surveys indicate that far more is being accomplished in the school health program

when the public health nurse gives major effort to family health and teacher guidance rather than to infrequent direct child contacts. Many more persons are interested in the health program than when the nurse tried to do everything and teachers seem to be more interested in the health problems of children.

Principles Governing School Lunches

THE JOINT Committee on Health Problems in Education of the National Education Association and American Medical Association affirms the following fundamental principles governing the school lunch:

1. The school lunch, contributing as it does to the child's nutrition, is a fundamental factor in the general health of that individual and, therefore, necessarily becomes a part of the school health program and, therefore, of the educational program as a whole.

2. The school lunch inevitably contributes positively or negatively to the child's education and, therefore, constitutes a vital part of the child's educational experience.

3. Since many pupils, especially in rural areas served by consolidated schools, live too far from school to go home for lunch and many children of working parents eat lunch away from home, the school lunch occupies a place of great importance.

4. The school lunch should be planned primarily for its nutritional and educational significance and should not be used as a means of making profit for the school or for a concessionnaire. In some instances where children cannot pay the full cost of their lunch, arrangements must be made for feeding certain children free. In other instances all children may have to be fed at a deficit which may have to be met from outside funds or by the utilization of available foods (surplus, or donations) for which no payment in cash needs to be made.

5. Because of its nutritional and educational implications the school lunch should emphasize foods of fundamental nutritional importance. Candies and soft drinks are not in themselves objectionable unless emphasized at the expense of basic foods or unless they are exploited for profit.

6. The sanitation of the school lunch is important because of the immediate harm that can result from contaminated, spoiled or infected food. Even when no demonstrable catastrophe occurs, the slovenly or unsanitary handling of food is an unfavorable educational experience for those who participate in the serving or consumption of food under unsatisfactory or other undesirable conditions. The sanitary requirements for school lunches have been set forth by the Joint Committee in another publication entitled "Sanitary Requirements for School Lunches." (See page 100).

7. In view of the educational significance of the school lunch, the Joint Committee believes that regardless of the source of funds, food supplies or other contributions, the administration of the school lunch program should be a function of the department of education, with sanitary supervision by the department of health. Financial aid from outside sources should be made available under conditions which do not interfere with local control of the projects to meet local needs.

8. Every advantage should be taken of technical assistance available, from state or federal sources if such technical assistance is not available locally. Continuous efforts are necessary to provide more trained persons for work in connection with school lunches.

9. The popular principle of a hot dish with the school lunch does not in itself assure a significant contribution to the child's nutrition unless the hot dish is composed of foods which tend to make a balanced diet when eaten in conjunction with the customary box or pail lunch, consisting of sandwiches and dessert. In certain localities and at certain times of the year a fruit or vegetable salad would be far more valuable than merely serving a hot dish.

Nurse Interview in the Tuberculosis Clinic

By KAREN E. MUNCH, R.N.

A METHOD of demonstrated value which is receiving increased emphasis in giving public health nursing services to tuberculosis patients and their families is the clinic interview or conference. Opportunities for such interviews or conferences occur at the first visit of the patient to the clinic, as well as subsequent visits—at the time of history taking, after the chest x-ray, and after medical examination by the physician.

Too frequently, the concept of the nurse's function in the clinic has been limited to routine history taking, preparing the patient for physical examination or treatment, taking temperatures, weighing and the like. Too small a portion of her time and effort have gone into teaching, which is her primary function. The teaching interview in the clinic is not to be regarded as a substitute but rather a complement to the public health nurse's work in the patient's home.

At the time of the first clinic visit, before the x-ray and medical findings are known, the nurse's instructions will be more or less general in nature, concerned with methods for the prevention and spread of disease. For example, the patient's cough offers an opportunity to demonstrate how the mouth and nose can be covered to prevent spray infection to others. Hands are washed after the demonstration as an extra precaution. When the patient's temperature is taken, the cleansing of the thermometer with soap and water may be utilized as an occasion to discuss approved methods of cleaning dishes and toilet articles.

In modern clinic practice, it has been found that many who come to the clinic do not have symptoms but come primarily for an x-ray. With these patients the nurse may not have an opportunity for more than one conference on general health matters. However, for some of them, the x-ray examination will indicate a need for further examination and follow up. Other patients come to the clinic because of definite symptoms, requiring a complete history and examination immediately. To these patients, the nurse needs to explain carefully the reasons for clinic procedures, such as need for complete history, repeated x-rays, medical examinations, and laboratory tests.

Such explanations may seem relatively time-consuming to the busy nurse, but initial understanding and recognition by the patient of the clinic personnel's interest in his welfare is important in the continued treatment of the tuberculous patient. Thus prepared, he is more receptive to the next step in his diagnosis and treatment.

It is well known that a detailed history of the patient, bringing out information regarding his symptoms both past and present, the health status of other members of the family, social and economic conditions, and other pertinent facts, is vitally important in the understanding of the patient. Many times this information can be completed on the first visit, but occasionally it may be necessary to defer the full history and emphasize only those facts that are the basis for his visit to the clinic. The patient is after all more interested in his present symptoms and what can be done about them, than in relating an extensive history of his past illnesses, and those of his family.

It is quite important that the nurse be present at the time the patient is examined by the physician. Although her activities here are often thought of as being limited to draping the patient and handling the records, she is frequently able to give the physician additional information regarding the patient.

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Also, hearing the physician's instructions to the patient will enable her to do a more constructive job at the time of her conference with the patient, and at the time of subsequent home visits.

THE CONFERENCE between nurse and patient, which usually follows the physician's examination and his discussion with patient of the diagnosis, offers an unusual opportunity for the nurse to explain in more detail just what the findings and recommendations of the physician mean. Even though the patient's reaction to the diagnosis may vary from complete and placid acceptance to violent rebellion and rejection, the instruction given at this time must be pertinent to the diagnosis, and concerned with the patient's particular problems. This is not the time for generalization in teaching. The patient is interested in his own condition, and what should and can be done about it. Obviously, the nurse needs to know the exact status of the patient's condition before she can plan with him intelligently for his care. Is his a minimal, arrested, or apparently cured case of tuberculosis? Has he a more advanced or an open infectious case, or is he a contact to an open case, or to nontuberculous persons?

The patient, whose case has been diagnosed as minimal, arrested, or apparently cured needs specific instruction as to what to do to protect himself and his family. Because of lack of symptoms, understanding on the part of the patient with a minimal lesion of the significance and reasons for continued medical supervision is of great importance. He needs to know why the physician's recommendations should be followed, the reasons for rest, a well balanced diet, and good personal health practices. While the arrested patient will need continued medical supervision in order to prevent reinfection, the apparently cured patient may need only limited supervision, unless other recommendations are made by the physician. The importance of x-ray examination of all household associates must be borne in mind, and with all three types of patients this should be arranged for at the time of the clinic interview. This may be the means of finding the source case which is of primary public health importance.

The conference with the patient who has more advanced tuberculosis will be of a somewhat different nature. He usually does not need to be told he is sick, since his symptoms tell him that. However, he needs to be warned of the danger that positive sputum presents to others, as well as to himself. The nurse will have to plan carefully how much can be taught in this first conference, but the instruction must include the facts of primary importance for the immediate care of the patient and protection of his family.

Some of these facts are:

1. The importance of starting medical supervision and treatment immediately.
2. The methods of preventing the spread of infection.

Care of coughs and sneezes—how and what to use to cover the mouth and nose.

Approved methods of disposal of sputum—flushing of tissues in toilet, placing of tissues in paper bag and burning. If a sputum cup is used, how to disinfect sputum and cup.

Care of dishes, washing them with plenty of hot water and soap, separately from those used by the rest of the family.

Necessity of having individual towels, wash cloth, tooth brush, toilet articles, and keeping them separate.

Significance of washing hands frequently, always before eating and after coughing or sneezing.

Importance of avoiding close intimate contact with others, such as sharing a common bed, kissing, et cetera.

3. The need of protecting family contacts, especially young children and adolescents from exposure.

In discussing these facts, visual aids such as the isotype charts prepared by the National Tuberculosis Association are very helpful. From these, the patient can see what actually happens. For instance, the chart, "Why Rest the Lung and How" gives a very clear idea of why complete bed rest is necessary, if the lung tissue is to be given a chance to heal. The chart, "Tuberculosis Germs Spread from the Sick to the Healthy," shows how far germs can be carried if coughs and sneezes are not properly covered. Pamphlets and written instructions for the patient to take home are also valuable. These should be discussed with the patient, and the sections most pertinent to him checked. The importance of hospitalization when advised is explained in detail and the patient should be encouraged to accept this type of

care. The patient can be helped to understand the advantages of this to himself and family, and the difficulties of receiving proper care and maintaining complete isolation at home. If pictures or booklets of the hospital can be procured, they will be an aid in explaining the hospital routines and requirements.

BECAUSE TUBERCULOSIS is a disease of long duration, there must be thoughtful consideration of the social and economic condition of the patient. This frequently adds to anxiety and may even be the patient's reason for not wanting to accept the diagnosis or treatment. Naturally patients worry about what will happen to their families, if they go to the hospital. They are confronted by the problems of financial support for the family, the care of children while the mother is away, and a host of others. In order to help meet these problems, the nurse must be well acquainted with all the resources of the community, explain them to the patient and arrange for necessary referrals to appropriate agencies, so that the family is assured of needed help.

Other members of the household frequently accompany the patient on his visit to the clinic. This is an opportune time, not only to give them a clearer understanding of tuberculosis and how they can help and cooperate in the care of the patient, but also to arrange for their examination as "contacts." Also this is the time to impress them with the need for repeated examinations over a definite period of time. Most clinics today have adopted a standard procedure for examination of contacts. The procedure carried out in the New York City Department of Health is discussed, in "Simplified Procedures in Tuberculosis Control," by H. R. Edwards and A. B. Robins, in the *American Journal of Public Health*, May 1943. The procedures discussed in this article meet the needs of the vast majority. Each individual should be carefully instructed to visit the clinic or his physician immediately if symptoms develop, regardless of whether he is due for a clinic examination or not.

In order to maintain the interest and cooperation of any patient examined, it is important that he be informed by the physician of the results of his examination. A negative x-ray means that at this time there is nothing of note, but periodic x-rays particularly to those over the adolescent age are necessary as evidence of disease may develop later. The patient should be told of these results as known, and the reasons for periodic medical supervision as long as indicated. Frequently, problems will be discovered that are not directly related to tuberculosis but which are important to the patient and family, and regarding which further explanations or help may be needed.

It is not only at the patient's first visit to the clinic but also on subsequent visits that opportunities present themselves for the nurse to assist both the patient and family or contact. On a return visit, the nurse is interested to inquire into what has happened to the patient in the interim, and how he has been able to carry out the recommendations made at the previous visit. This gives the patient a chance to ask about parts of the instruction that were not quite clear to him, and the nurse an opportunity to repeat needed instructions. Some questions that arise may need further clarification by the physician. Likewise, after the medical examination, advice given at the previous conference may need to be amplified or revised. The patient may have become aware of new problems. He or other members of the family may want to tell the nurse how they have been managing and ask her opinion about this.

WHEN PATIENTS discharged from hospitals return to the clinic, unparalleled opportunities are offered for the nurse to assist them in their readjustment and rehabilitation. The change from a controlled environment, such as a hospital, to the greater freedom and responsibilities of the home is not infrequently the cause of relapse. Therefore, it is of the greatest importance to convince these patients of the need for close continued supervision and medical advice. This is particularly true if a patient has been told that he can return to part- or full-time work. There is hardly a patient discharged from a hospital who should not restrict some of his activities upon his return home. He will need additional rest, which means an early retiring hour, rest periods during the day, restriction of recreation and other activities that use up an undue amount of energy. The nurse can

inform the patient of the possibilities for re-education or training in some occupation suitable to his needs and abilities, if such plans have not been started in the hospital. Encouraging and assisting him in visiting the state, or local rehabilitation services nearest his home may prevent a good deal of discouragement. In many localities, home economics workers are available to demonstrate to the housewife how to carry on housework with the least possible strain.

Obviously the nurse who is to carry out satisfactorily the functions mentioned must not only have considerable knowledge of tuberculosis but also be well acquainted with approved and up-to-date educational methods. She must know the clinical aspects of the disease, methods of prevention and control, the age groups which are most susceptible, and how this differs according to sex, and the racial, nationality, and economic groups in which tuberculosis is most prevalent. In other words, she needs not only to have clinical and epidemiological knowledge of the disease, but must be able to translate this into practical suggestions that the patient and his family will understand and use.

To summarize briefly, much has been written regarding the role of the public health nurse in the tuberculosis control program. Various functions and standards of procedure have been agreed upon. It is well, however, to review periodically how nursing service in a chest clinic may be fully utilized in keeping with the accepted role of a public health nurse. I have reviewed some of the teaching opportunities prevalent in the clinic; methods of establishing rapport, acquainting the patient with clinic procedures, interpreting results of examinations, and giving specific instruction about care and prevention of tuberculosis to patient and family. It must be understood that the clinic interview or conference is only a part of the teaching program for total care of the patient. It supplements work with the patient and family in the home, hospital, school, and place of employment.

BIBLIOGRAPHY

Chadwick, Henry D., and Pope, Alton S. The Modern Attack on Tuberculosis. The Commonwealth Fund, New York, 1942.

Derryberry, Mayhew. The Nurse as a Teacher of Tuberculosis to the Family. Transactions, National Tuberculosis Association, New York, 1939, p. 236.

Edwards, H. R. Tuberculosis Case-Finding. National Tuberculosis Association, New York, 1940.

Grant, Amelia. Nursing, A Community Health Service. W. B. Saunders Company, Philadelphia, 1942.

Hayes, Edward W. Tuberculosis As It Comes and Goes. Livingston Press, New York, 1943.

Hetherington, H. W., and Eshleman, Fannie. Nursing in Prevention and Control of Tuberculosis. G. P. Putnam's Sons, New York, 1945.

Hudson, Holland, and Fish, Marjorie. Occupational Therapy in the Treatment of the Tuberculous Patient. National Tuberculosis Association, New York, 1944.

Lincoln, Louise A. Solving Tuberculosis Problems in Wartime. PUBLIC HEALTH NURSING, August 1944, p. 394.

Longhurst, Grace M. Tuberculosis Nursing. F. A. Davis Company, Philadelphia, 1941.

Mattison, Berwyn F. Unexamined Tuberculosis Contacts. PUBLIC HEALTH NURSING, December 1943, p. 673.

National Tuberculosis Association. Tuberculosis Clinic Manual. Report of Committee on Clinic Standards. The Association, New York, 1938.

Parran, Thomas. "Tuberculosis Control Program of the U. S. Public Health Service." *Journal of the American Medical Association,* February 13, 1943, p. 520.

"The Social and Vocational Rehabilitation of the Tuberculous: A Survey Presented with the Cooperation of the Rehabilitation Department, National Tuberculosis Association." *Occupations,* April 1937, p. 581.

U. S. Public Health Service. Tuberculosis in the U. S.: Graphic Presentation. National Tuberculosis Association, New York, 1943-45.

Staff Education

Old Concepts in a Changing Situation

By RUTH E. TELINDE, R.N.

EVERY TYPE of educational enterprise is today in a stage of evaluation and change. This is a natural outgrowth of the new values and attitudes, the social unrest and human struggles of one kind or another in our present society. Institutions for formal education cannot continue in their prewar role and many are in the process of taking stock of their programs, faculty, educational methods, as well as their broad aims and objectives. Changes have already been observed in many institutions.

Less formal educational groups, such as we find in service agencies, are also considering how the old patterns will fit into the new. Public health nursing agencies have always, to a lesser or greater degree, been aware of the need of continuous educational instruction and guidance of their staff members after employment. The extent of the educational programs and methods used have depended on factors such as professional and lay leadership, available resources, size of the staff, personnel qualifications, and service needs. During recent years the employment of unprepared personnel, staff shortages, new and increased responsibilities, have all tended to change the need and the type of program. Developments in the field of public health and social welfare are a constant reminder of the tremendous job of keeping public health nurses prepared for their contribution to the total service. The war has changed the importance of many problems. It has also changed the people with whom we work, those who do the work, and how it is done.

Because we are aware of the fact that social change affects the way we as public health nurses carry on our daily tasks, it behooves us to consider the methods of keeping ourselves alert, on the job, and informed professional workers. An attempt will be made here to review some of the well established concepts of learning and teaching and their application to in-service public health nursing education.

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PRINCIPLES OF LEARNING AND TEACHING

If any educational experience is to be effective, persons giving leadership to the enterprise must be aware of and apply the principles on which learning is based. A brief consideration of some of the pertinent characteristics of the learning process with application to in-service education may be helpful.

1. "The learning process proceeds best when the numerous and varied activities are unified around a central core of purpose, when the learner's interest is in the activities and products, when the learner identifies himself with the purpose through originating or accepting it."[1]

In applying this principle to staff education we envision the need for careful, cooperative planning between administrator, supervisor, and staff workers. The public health administrator who is launching an intensive program in public relations, venereal disease, or tuberculosis control must carry along with him in study and planning all personnel of his agency so that the interest of each person is "in the activities and products" and so that the "activities are unified around a central core of purpose."

Educational programs for staff members planned and executed without the participation of those most vitally concerned is much less effective than when all share. Joint

planning may be done through representative committee work or direct participation by all. The method will, of necessity, be determined by such factors as the size of the staff, traveling distances, educational background of the staff, and the working philosophy of the administrator.

This principle also implies the need for unification of the educational program. Long range purposes must be determined and the relationship of one unit to another made clear. The leadership and guidance by the administrator or supervisor may be needed here, as individual staff members may not have the background of experience to appreciate the value and to see the service as a whole. Sharing administrative problems and plans with staff personnel is in itself an educational experience.

2. "The learning process is experiencing, reacting, doing, undergoing. Scores of different learning activities are utilized."[1] This implies that a variation in activity is a vital part of learning, and without activity little or no learning takes place. The activity may be a part of the planning process, through discussion, reading, collecting of data, analysis and evaluation of materials, interviews with community leaders, observation of special activities or institutions, et cetera. As the plan is put into effect, the methods used should promote exchange of ideas, deliberations, testing, demonstration, and group discussions. The evaluation of the program and application to the specific work of each individual staff member also gives opportunity for activity. Mark VanDoren in *Liberal Education* says, "Education is of hand as well as the head and heart. Some of the gray matter seems to be in fingers which had better be familiar with their hidden wisdom." . . . "Knowing includes knowing how to do whether in poetry or in mechanics, whether with levers or with laws; and a time promises to come when the distinction between brain and hand is divested of its present snobbery."[2]

One authority in staff educational methods says, "The goal of the supervisor should be, not so much that the nurse acquire new knowledge and skills, but rather that she use these tools in her daily work to the end that she becomes an increasingly able public health nurse."[3]

3. "The learning products accepted by the learner are those which satisfy a need, which are useful and meaningful. Learning products which are extraneous to need and purpose are either rejected or learned only superficially (actually they are not truly learned at all)."[1]

This implies, of course, that staff education programs should be practical and useful; that the learner is satisfied with the methods used and the results obtained.

This is sometimes difficult to attain, particularly through group activities, because of individual differences and variation in service needs. The good of the greatest number, or the good of the service as a whole may sometimes have to be given precedence over the individual interest or need. Individual learning experiences will have to be considered in addition to group activities.

In order to have educational programs a satisfying experience for staff nurses, the nurse must be able to see how new ideas presented may be used in her service. The supervisor and administrator must make it administratively possible for her to put her learning into action or all is lost and discouragement results. This cannot be overemphasized.

4. "The learning experience initiated by need and purpose is likely to be motivated continuously by its own incompleteness. Further stimulation through subsidiary purposes suggested by the teacher may be necessary."[4]

Once a sound educational program has been actively established and staff members feel it an integral part of their work, it progresses rapidly. Less and less leadership and stimulation may have to be given by the administrator or supervisor. At least the leadership may change in its nature. The growth of individual staff members is thus promoted.

5. "The learning process and its products are affected by the level of maturity of the learners as indicated by various measures of chronological, mental, emotional, physiological, and social age; by the nature and amount of previous experience as indicated by tests of informational background, interests, needs; by fatigue, etc."[4]

An overall picture of the background and needs of staff members will be in the hands

of the supervisor. This can and should be used in individual as well as group educational planning. Care will have to be exercised in making known to other staff members the specific needs of individuals or variation in professional and educational levels.

The variation in educational and experience levels of staff members is one of the difficulties in program planning. This has been particularly difficult during the war period when personnel practices as to qualifications and educational requirements have varied tremendously. The use of professional tests may be helpful if there is too great a variation in the background of the staff, or if uncertainties exist as to a starting point.

FITTING THE METHOD TO AGENCY, RESOURCES AND NEEDS

Staff education programs, if based on sound psychological principles of learning must vary and the how of doing be individualized. Some generalization as to the method may be useful.

In general, types of programs may be classified into two major areas: (1) planned and executed within the agency itself and (2) planned through and with an educational institution. Each type of program compliments the other and one should not supplant the other.

The *first type* of program should be carefully and consistently planned from year to year, month to month, with the specific service problems within the agency, and the needs of the staff as a whole kept in mind. Special groups, such as new staff members or staff selected to do a specific service job, will require a program in addition to that planned for the entire staff. Regularity in meeting, at a time convenient for the majority of staff members, spaced near enough together to make an easy carry-over from one meeting to another should be thought of. If the group of staff nurses is large, discussion meetings may be held between the more formal type of sessions. Monthly educational meetings for the entire staff may be practical and effective.

The *second type* of program centers around the more formal types of experiences available within an educational institution. This phase of the plan may have less relationship to the specific job. It can be individualized and should broaden the cultural as well as the professional background of the nurse. It in no way takes the place of the first type of educational scheme but should make it more effective and meaningful to the individual. On the other hand, the day-to-day experiences of the worker in the field help to stimulate interest in class work and give a student the opportunity to bring problems for study and group discussion.

If a university or college is within geographical proximity to the agency, part-time work or extension courses may be arranged. Workshops and short intensive courses have been popular during the past few years. Administrators and staff personnel themselves have appreciated this type of work, particularly during the war years, because less time is consumed. Another advantage of the workshop is the fact that students come with problems for study in mind. Effective results have been observed where groups of faculty or staff members from one institution or agency participate in a workshop together. The problem brought to the workshop would thus be a problem of the group, the solution of which would be meaningful to the entire school or agency. A workshop of this type has been carried on in my own institution recently for teachers, dental hygienists, and school nurses of three centralized rural schools. In this instance the panel of university faculty members went to the school. The problems studied centered around the teaching of health in the secondary schools and members of the panel contributed according to their own specialty as advisers to individual students as well as group leaders.

None of these experiences takes the place of periods of full-time study. The nurse who is seriously planning a professional career should work toward this objective.

SUMMARY

1. Educational experiences of all kinds should be based on sound psychological principles of learning.

2. All members of the agency staff, including administrators and practitioners should participate in the planning, execution, and evaluation of the educational program.

3. Improvement of the service rendered should be the ultimate goal of the program.

It should be purposeful and unified, based on careful consideration of service needs as well as the interests of individuals.

4. Two general types of programs may be planned. One, within the agency itself, and the other through and with an educational institution. Each supplements the other.

5. Periods of full-time study in an educational institution should be the ultimate objective of any nurse who plans a career in public health nursing.

REFERENCES

[1]Burton, William Henry. The Guidance of Learning Activities. D. Appleton-Century Company, New York, 1944, p. 212.

[2]Van Doren, Mark. Liberal Education. Henry Holt and Company, New York, 1943.

[3]Hodgson, Violet H. Supervision in Public Health Nursing. The Commonwealth Fund, New York, 1939, p. 123.

[4]Burton, op. cit., p. 213.

American Council on Education, Commission on Teacher Education. Teachers Education in Service. The Council, Washington, D.C., 1944.

———. Teachers for our Times: A Statement of Purposes. The Council, Washington, D.C., 1944.

Freeman, Ruth B. Techniques of Supervision in Public Health Nursing. W. B. Saunders Company, Philadelphia, 1944.

Heaton, K. L., Camp, W. G., and Diederich, P. B. Professional Education for Experienced Teachers. University of Chicago Press, Chicago, 1940

Mueller, A. D. Principles and Methods in Adult Education. Prentice Hall, Inc., New York, 1937.

FLUORESCENT LIGHT NOT HARMFUL TO VISION

IF PROPERLY installed and properly used, flourescent light should not cause eyestrain. This is the conclusion of the Joint Committee on Industrial Ophthalmology of the Section on Ophthalmology of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology in its report to the Council on Industrial Health of the AMA, published in the *Journal* of the AMA, August 25, 1945. The Committee's statement follows:

Fluorescent lighting has been regarded by physicians and others as possessing harmful qualities not found in other forms of artificial illumination or in daylight. Both the ultraviolet and infra-red components have been suspected. The Joint Committee on Industrial Ophthalmology, after consultation with specialists in the production and use of light, holds the following opinion:

1. The ultraviolet energy from clear blue summer skylight is three to four times as great per footcandle as fluorescent light.

2. Light from fluorescent lamps resembles daylight more closely than that from tungsten-filament lamps. This color resemblance to daylight is considered a desirable quality.

3. Infra-red energy found in fluorescent lighting as now manufactured produces no known physiologic effect except that due to heating. Fluorescent light generates less heat per candlepower than tungsten lamps.

4. Glare occurs in any system of lighting. Its solution rests with illuminating engineers.

5. Individual differences occur in the level of illumination (footcandles) required to provide a satisfactory degree of visual efficiency and eye comfort. Twenty footcandles is essential for such critical tasks as reading. Higher levels of illumination are desirable for prolonged seeing, for discrimination of fine details and where low contrast prevails. These standards can be readily maintained in working places through use of properly installed fluorescent lighting.

6. Excessive light may produce symptoms of eyestrain in susceptible individuals regardless of source. Constitutional factors should be corrected as well as the amount and kind of light.

7. Noticeable flicker is largely eliminated in modern fluorescent installations.

Students Take Part in a Community Program

By ROBERTA E. FOOTE, R.N.

MANY TRAINING centers have special opportunities to offer students. The one we stress is student participation in the program of a large rural-urban health department where there is a high degree of cooperation between the various divisions and with the community in solving joint problems.

From the beginning, the field training center of the St. Louis County Health Department has tried to practice the theory that doctors, nurses, and sanitarians must all know each other's viewpoints and problems. Consequently, public health nursing students spend considerable time with the health commissioner and sanitarians as well as in nursing.

Our training center, near St. Louis, Missouri, had 21 students from 4 universities during 1945 and 4 senior cadets selected and assigned by the Missouri State Board of Health. These included Negro and white nurses and one Japanese-American. We plan an individualized program with each student based on her own objectives. While the general plan was worked out by the heads of departments, under the leadership of Dr. E. G. McGavran, Commissioner of Health, the student advisers meet monthly with the educational director to consider methods for improving the program. Our staff enjoys the students and considers them an integral part of the health department program. We have been operating as a field training center for over three years. In the future, we hope to round out our program to include work with health officers and public health engineers if the budget permits.

That our present plan for coordination of effort can lead to good results is illustrated by several projects completed by public health nursing students.

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The first is an example of coordinated effort in the field of sanitation:

In April 1944 two women brought water samples from their wells to the sanitation division. They wished to know how they could obtain a safe county water supply for their street, the last street in their area not having a water main. The samples showed dirt, worms and larvae. One said, "My doctor doesn't think it would do me any good at all to drink that water now that I'm in a family way." Members of the sanitation division surveyed the wells and found them to be mostly the shallow, dug type with inadequate protection. The St. Louis County Water Company informed us that a neighborhood improvement association would need to be formed. Also, $36.78 plus the tax and the cost of connecting to the main would need to be collected from each family and deposited before work could begin.

A meeting of the 19 neighbors was called by the women who had brought in the water samples. Our handsome, blond sanitarian explained the situation and enthusiastically described the advantages. Nothing happened. As the women said, "There are some that are foolish enough not to want to put out the money."

About a year later, however, a new neighbor moved to Sylvan Drive and a new public health nursing student was assigned to this area. The student made herself thoroughly familiar with the various steps in securing county water as part of her survey of the community. As she went about her family health work, she talked with the people about the project, pointed out its value, and answered their questions. One morning she called on one of the mothers who was doing her washing. This home had a makeshift water pressure system of its own, which, on wash day, of all times, had broken down. The irate mother decided then and there that county water, always available in the faucet, would be worth paying for.

One of the landlords seemed never to be at home. The new neighbor sat on his doorstep for a whole morning until she got permission to collect his share of the water assessment from the rent of his Sylvan Street tenant. The last of the 19 householders refused to pay. This meant dividing her responsibility among the others. The additional burden was shouldered and the money deposited with the water company in August 1945.

Safe water will soon be flowing into the homes of Sylvan Drive thanks to the pioneer spirit of American homemakers plus the com-

bined efforts of the nurse and sanitarian. The sanitarian feels that the project would not have been completed without the added impetus which the nurse could give it in her daily work.

The second project shows the coordination of student effort with that of field and clinic nurses:

When the beautiful new health center was opened, the staff was eager to make it truly a teaching center. Maternity clinic seemed the best place to begin. However, the nurses regularly assigned there could not add group discussion to the individual conferences with each patient which were a regular part of the clinic. The students came to our assistance. At first those who were interested chose and prepared their own subjects with the approval of the educational director. Classes were held periodically with frequent gaps between. This was the necessary pioneering and helped establish the fact that the clinic could be managed so as to allow 30 minutes for this activity. Later one of the university students made a careful analysis of clinic records to determine how early in pregnancy patients began visiting the doctor and how often and how long they came. The study showed that most patients were in clinic from the fifth through the ninth month. With this as a basis, the student planned a series of five lessons. The main topics were hygiene of pregnancy, nutrition for the mother and her family, reproductive process, baby's needs and his place in the family, and the baby's bath.

The same topic was discussed at both the Tuesday and Thursday clinics for a two-weeks period. Then the next subject was taken up. Thus the mothers who were coming every two weeks had a different lesson at each clinic visit. The whole series was repeated twice during the five-months period so that a lesson missed might be made up later.

Although, with this system of rotation, the students do not choose their subjects, each makes her own plans for presenting the material. Both in pre-planning and follow-up conferences, we try to help the students learn the philosophy and techniques of true group discussion. Many of them have had no previous experience of this kind and are delighted to find how much the mothers can contribute if given an opportunity. Thus they are furthering their own growth as well as contributing to the quality of the agency's service.

Student participation, however, was not enough. A maternity class committee was formed consisting of the clinic supervisor, educational director, and two interested field nurses, one of whom suggested the idea. This has given continuity to the plan and made it possible to iron out difficulties such as the problem of the laboratory technician's coming too late to allow time for the discussion period. The staff nurses now fill in any gaps between students by doing the teaching themselves. The committee plans to meet at a time when the person completing a group of lessons as well as the person about to begin can be present. In this way, many good suggestions have been made and put into practice.

A recent survey by another student shows that our attendance from April to November 1945, was as follows:

Registered patients	182
Mothers not attending class	50
" attending 1 class	56
" " 2 classes	27
" " 3 classes	23
" " 4 classes	17
" " all classes	0

The need to see the social worker or dentist sometimes makes attendance impossible. Some mothers prefer not to come to class. Others register too late in pregnancy. While the survey shows that we still have problems, group teaching has become a regular part of maternity clinic.

The third project shows how a public health nursing student assisted a school to prepare for the tuberculosis screening program offered to high schools and school personnel by the Health Department in cooperation with the Tuberculosis Society of St. Louis.

The school health summary for St. Blank School shows that in 1944 and 1945 the active health committee of room mothers, organized the previous year, continued to function. After careful instruction by the nurse, the mothers completed the health cards, tested the vision, and gave the audiometer tests. It was then time to make plans for the 35mm chest plates. The students' school record shows the following activities:

On a Friday in March 1945 Father X, head of St. Blank School, met with the chairman of the mothers' health committee to discuss x-raying the high school students as a tuberculosis case-finding measure. They planned to combine St. Blank with two other high schools and to x-ray teachers, cafeteria personnel, and volunteer mothers as well as students. The need for a preliminary program of education on tuberculosis was stressed and a meeting of teachers from the three schools, together with student and parent representation, was scheduled for the next day to discuss how to carry out the education program.

At this second meeting a public health nurse from the Health Department explained the procedures involved in mass x-raying. The public health nursing student discussed the integration of a continuing and effective educational program on tuberculosis into the curricula of the schools. Plans were then made by the group to secure educational literature and films from the Tuberculosis Society, and subcommittees set to work on ways of including tuberculosis in the teaching units of the various schools.

The following Monday a general school assembly was called in the morning at St. Blank which students of one of the other two schools were invited to attend. The film, "Good-bye, Mr. Germ," was shown, followed by a lively question and answer period in which the students asked the questions under the leadership of Brother C, a teacher, and public health nurses gave the answers. In the afternoon the film, "Another to Conquer," was shown at the other school with a similar question and answer period.

On Wednesday Father X and the health committee chairman met to arrange a convenient time for the various groups to be x-rayed. The first plates were made on Friday, but here the first snag occurred in the smoothly running schedule. The x-ray machine broke down and plates had to be done over. Everybody was very understanding and a few days later 188 x-ray plates were taken. All were negative except that for one of the adults who had been working with the children. This person's tuberculosis was found to be inactive after consultation with the family physician who is keeping this patient under close supervision.

The public health nursing student's last notation of the year states, "Records for year almost completed. Plan for Health Committee to continue next Fall . . . Mother Y seems to feel that a good year's work has been accomplished."

The work did not cease with the close of school, however. The sanitarian, called in at the nurse's suggestion to help Father X solve a problem in regard to the plumbing, had been consulted about an addition to the school plant to be made during the summer. The sanitarian says that, when an alert public health nurse suggests that he be invited in early for consultation, his relationship with the school is excellent and the money is wisely spent for the best interest of the children.

In the fourth project, a student contributed data needed by a professional committee which met to formulate a long-time program of nutrition teaching.

For some time students had been conducting group discussions in some of the child health conferences much as they began in maternity clinic. Also the community education section of the St. Louis Dietetic Association had generously offered to teach in some of the conferences. They had completed several series of nutrition lessons. It was time to bring all of our experience together around the conference table.

A meeting was planned to include such interested people as the state nutrition consultant, our maternity and child health consultant, members of the community education section, the chairman of volunteers, several representatives from the nursing division of the Health Department and interested students. Many questions were discussed:

How nutrition teaching began in our conferences.
How can the conference personnel help the nutritionist become a part of the conference?
How can the nutritionist help the mothers change their food habits?
Should the nutritionist stay in one conference over a long period or serve on a rotating basis?
How can the conference be organized so as to make group discussion possible?
What should be taught and how should the topics be spaced?

Facts were supplied by one of our senior cadets. In brief, she reported:

A study of the attendance cards of 277 children attending the conference during the last five years,

was made first as an aid for setting up lesson plans both for the nutritionist and the nurse. This study brought out the irregularity of clinic attendance patterns. The average number of visits per child was 7. There was no regular spacing of these visits with the exception of the 6 visits made at the time the child received immunizations.

The age at which the children entered clinic ranged from under 1 month (15 children) to over 6 years (2 children). However, the largest number in any single age group was 62 enrolled at 1 or 2 months of age. The age at which the attendance showed the immunization pattern was 9 months. (This is the time when the children are brought regularly at weekly intervals until immunizations for diphtheria, whooping cough, and smallpox are completed.)

The study brought out the fact that the attendance picture was so varied that it would be unwise to set up a lesson plan requiring any regularity of attendance. The "immunization pattern" necessitated a plan which would run at least 7 weeks before being repeated to avoid duplication for these mothers. The age of the children attending covered the entire range from infancy through the preschool period, so lessons would need to be planned to cover both the infant and preschool group.

As a result of the meeting and in line with the facts presented, a series of five independent lessons on simple family nutrition was worked out by the dietetic association. A yearly rotating schedule was set up by the Health Department supervisors so that each of the 13 child health conferences would be given a series of talks and demonstrations on nutrition semi-annually or at least annually. A demonstration center at one conference was continued in order that student dieticians from the two universities participating with the dietetic association could observe an experienced nutritionist from the St. Louis Dairy Council before beginning their own discussion groups.

A demonstration kit including such items as an electric plate, double boiler and strainer was purchased by one of the nurses from funds supplied by the American Legion Auxiliary of Pine Lawn to be used both in maternity clinic and in the child health conferences as needed. A chart was prepared by the educational director whereby the teaching of other subjects than nutrition could be alternated with the nutritionist's schedule. The staff is working toward the goal of regular, carefully planned group discussion at each child health conference. The senior cadet contributed toward this end by leading group discussions for 11 weeks in one conference as well as by presenting the facts which helped define the problem.

Thus the students are learning from their own experience that in union there is strength. Whether the problem requires the combined efforts of several divisions of the Health Department, or the assistance of other well established agencies, or the shared experiences of mothers in the clinics, homes or schools, we have demonstrated that when all work together the problem approaches solution.

Sale of "Savings" Bonds Continues

THE U. S. Treasury has authorized the continuation of the bond program as a peacetime operation. Known successively as Defense Bonds, War Bonds, and Victory Bonds, these securities will now be called U. S. Savings Bonds.

The basic motive of patriotism during the war has given way to an appreciation of the advantages of bond ownership, which may be listed as follows:

1. Analyses made by bankers and investment counselors of the Series "E" Savings Bonds prove this is the best medium in which to put one's savings.

2. You receive the highest interest rate of all U.S. government bonds—2.9 percent.

3. You have a short maturity investment—10 years.

4. You have bonds costing $750 guaranteed to mature at $1,000 which is a 33 1/3 percent increase in your original investment.

5. You do not have to worry about market fluctuations—the bonds are redeemable 60 days from issue date at a guaranteed price—never lower than the purchase price.

6. You may defer the federal income tax on the interest until ten years from now, when tax rates may be less.

7. Should you lose your bonds, you do not need to worry. The U. S. Treasury keeps a record of the owner's name of each bond and will replace lost bonds.

8. You are helping to keep the United States financially strong and powerful—an important factor in winning the peace.

The Conservation of Hearing in School Children*

HEARING is one of the most important avenues for learning, and is directly related to efficiency and safety in living. Defectve hearing is impaired health. Deafness and impaired hearing are major problems of public education, public health, and preventive medicine.

According to various estimates, approximately 60,000 school children in the United States are totally deaf. It is estimated that from 3 to 5 percent of the total population in the United States have some degree of hearing loss. The loss may range from a very slight one to total deafness.

Physicians indicate that hearing defects are due frequently to inflammation in the middle ear during infancy and early childhood. Hearing impairments in children often result from such communicable diseases as scarlet fever, measles, meningitis, colds and other respiratory infections, particularly if neglected. The majority of cases of impaired hearing are preventable; therefore, the first objective in a program of hearing conservation is the early detection of defects and removal of causes.

Early detection of defective hearing is one of the teacher's functions. A child may lose a considerable amount of hearing acuity without being aware of the loss and hence fail to seek medical aid until too late. The total problem is one of prevention, examination, diagnosis, treatment, and rehabilitation. Obviously, the school must play an important part in solving the problems of speech defects, retardation, inferiority complexes, and emotional maladjustments resulting from defective hearing.

The most effective means for reducing the high incidence of hearing defects is through close teacher observation, periodic testing of the hearing of all school pupils and the medical follow-up of those having defects. The alert teacher is expected to detect functional signs of impaired hearing in children by observing such things as inattentiveness, excessive noisiness, or inability to repeat accurately things heard. Tests of hearing should be made by a teacher or nurse under general medical supervision. The objective of mass screening tests is to locate pupils who have hearing deficiencies which justify a thorough otological examination and subsequent treatment by a skilled physician. In the mass testing of pupils, efforts should be made to avoid errors due to noise, haste in applying the tests, variations in the calibration of instruments used and the training and experience of the operator.

TESTING TECHNIQUES

The three most commonly used procedures for finding children with impaired hearing are the voice, the watch, and the audiometric tests. In the voice test, the whispered voice should be used. The child is stationed 20 feet from the teacher, faces away from the teacher, and one ear is closed with his hand while the other is tested. He is instructed to repeat words or numbers uttered by the teacher. If unable to hear at 20 feet, he is tested at 15 and at 10 feet. If he cannot hear at 20 but hears at 15 feet, the record is 15/20, and if he hears at 10 but not at 15 feet, the hearing is 10/20. This latter notation means that the pupil hears at 10 feet the words or numbers that a normal ear would hear at 20 feet distance. The voice test is practical and simple to administer, and may be used as a temporary screening measure.

*Recommendations relative to problems of the hard-of-hearing school child by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. Members of the committee are: N. P. Neilson, Chairman; A. J. Chesley; Glenville Giddings; Thurman B. Rice; and Willis A. Sutton.

Since there are so many varieties of voices, some testers prefer to use a stop watch. In this test, the room should be quiet and the pupil should keep his eyes shut. The examiner stands behind the child with the watch held in the palm of the hand toward one of the ears and on a level with it. The opposite ear must be covered or closed by means of finger pressure. Hold the watch near the ear and gradually carry it farther away. Repeat the test with the other ear. Variations in the loudness of tick in different watches makes necessary calibration of the watch. Record the distance at which the child hears the tick.

Development of the audiometer for measuring hearing acuity has made possible more accurate testing than could be done by the voice, watch tick, or tuning fork. The phonograph audiometer has been used in schools for screening purposes. Pupils suspected of having defects are retested by a pure tone or pitch range audiometer and those with significant hearing losses are referred to a physician, preferably an otologist, for further examination. But screening tests made with the phonograph audiometer fail to find more than 50 percent of the pupils who really have significant hearing losses. The limitations of this instrument are that it does not disclose losses for the higher frequencies and it cannot be used in testing pupils too young to write numbers. Hence, in securing equipment, the pure tone audiometer is preferable for testing school children of all ages. In recording the results of the hearing tests, an audiogram (chart) is used.

FOLLOW-UP PROGRAM

When a hard-of-hearing child is found, the parents should be notified and arrangements made for referral to the family physician or otologist for treatment.

Successful wearing of a hearing aid involves instruction and certain precautions. Opinions differ as to the earliest age at which a child can be expected to wear a modern hearing aid satisfactorily. Except in a few instances, a child 5 years old is not sufficiently advanced to understand the necessary instructions and to carry them out intelligently.

Recognizing that the modern hearing aid is a notable achievement, it is still a fragile instrument in the hands of an active child. The crystals in the microphones and receivers are delicate. The tiny vacuum tubes are easily damaged—the batteries become exhausted and too much moisture will render the aid unusable. The aids require careful attention which youngsters are not apt to give. Subjecting a hearing aid inadvertently to temperatures of 120° to 125° F. for several hours will make it inoperative. These temperatures are reached in a closed car in the sun on a hot summer day and also on the top of a radiator in the house during the winter.

Deaf and hard-of-hearing children should have their school programs modified. They may be assigned to special schools or classes for the deafened, to special classes for the hard-of-hearing. Whenever possible programs should be adjusted in the regular classroom. To compensate for defective hearing, special attention must be given to lip reading, speech correction, social adjustment, vocational training and occupational placement.

Children with hearing losses may be classified into three groups: (1) those in need of lip reading (2) those in need of lip reading and a hearing aid, and (3) those who need individual or institutional instruction. There has been great improvement in the quality and convenience of hearing aids in recent years. The selection of a hearing aid to meet the requirements of an individual should be made by a competent otologist.

RECOMMENDATIONS

1. That the program for conservation of the hearing of school children be an integral part of the school health program.
2. That the state department of health, the state department of education, and the state medical society of each state cooperate in formulating a practical, economical, and standardized program for conservation of the hearing of school children. Competent supervision should be available to insure adequacy and uniformity of the program.
3. That instruction in the conservation of hearing be included in college courses required for the training of teachers and nurses.
4. That the program in each state be uniformly applied in the public, parochial, and private schools.
5. That schools adopt definite plans for the testing of pupils, for securing the treatment of children with defective hearing, and

for special education for those with hearing losses.

6. That audiometers be owned by school districts having a school enrollment of 600 or more, and that the state furnish them for use in the smaller districts with limited budgets.

7. To insure uniformity and accuracy, that only audiometers accepted by the Council on Physical Medicine of the American Medical Association be used, and that only properly trained persons make the tests.

8. That schools educate children to avoid colds and other respiratory infections and to give proper care to the ears.

Schools may secure information from the following sources:

1. The American Society for the Hard-of-Hearing, 1537 35th Street, N. W., Washington 7, D. C.
2. The American Speech Correction Association, Terre Haute, Indiana.
3. The American Academy of Ophthalmology and Otolaryngology, 100 First Avenue Bldg., Rochester, Minnesota.
4. The American Medical Association Council on Physical Medicine, Hygeia, and the Bureau of Health Education, all at 535 North Dearborn Street, Chicago 10, Illinois.
5. International Council for Exceptional Children, National Education Association, 1201 16th Street, N. W., Washington, D. C.

GUIDE FOR INDUSTRIAL NURSES IN TUBERCULOSIS CONTROL

A RECENT publication of the National Tuberculosis Association, "Tuberculosis, Industrial Nursing, and Mass Radiography" by Julie E. Miale, is designed and written for the special purpose of helping the industrial nurse to meet problems stemming from the rapidly expanding application of tuberculosis control measures. An 80-page pamphlet, it summarizes wartime experience and supplies methods for handling preplacement examinations, mass surveys, and the employment and supervision of arrested cases.

In his preface to the manual, Dr. Kendall Emerson, managing director of the NTA, states:

"It is in and through industry that great advances in public health will be made in days to come. It is here that the next steps toward control of tuberculosis must be taken. Chest x-rays of large population groups are feasible and within reach; thus industrial control of tuberculosis becomes an attainable goal.

The nurse in industry plays an important role in the tuberculosis control program, even though she has been employed primarily to give nursing care in emergencies."

Dr. Wm. Arkwright Doppler, director of NTA's industrial relations, introduces the guide, pointing out the relationship of the disease to industry, the importance of control measures, and the place of the nurse in the control program. He states, "Industrial nurses constitute the largest single group of professionally trained persons who render health services to industry. The advent of industrial chest x-ray surveys for tuberculosis case-finding has added new responsibilities to already heavy duties."

The manual presents four principles considered essential to the industrial nurse before she takes any steps toward initiating a tuberculosis control program. She should:

1. Know the tuberculosis control measures in industry and what part she can play in carrying them out.
2. Work under the direction of the plant physician, whether he is full- or part-time or only on call.
3. Know the programs and procedures of the local official agencies who are legally responsible for tuberculosis control, as well as the regulations governing the control of tuberculosis.
4. Explore and consult with existing community sources to find out available facilities which might be used in setting up an "in-plant program."

Contents of the monograph include: tuberculosis control measures in industry; relationships; cooperating agencies; the industrial nurse as a teacher; how to organize a mass x-ray; x-ray findings; the nurse and follow-up. Selected references are given at the end and also an appendix of sample forms.

The booklet is available from the National Tuberculosis Association, 1790 Broadway, New York 19, N. Y., at 50 cents a copy.

Reviews and Book Notes

WITH LOVE, JANE

Letters from American Women on the War Fronts Collected and Edited by Alma Lutz. 199 pp. The John Day Company, New York. 1945. $2.00.

This is an important book. It should have been called something like "The Voice of Service Women." For that is what it really is.

Alma Lutz has rendered a real service in collecting these letters from nurses, Wacs, and other service women. The record they give of courage, endurance, and selflessness combined with vital usefulness is a record that should be preserved. Many bits of humor and accounts of interesting experiences enliven the grim stories, but in them all is deadly earnestness.

Nurses write: "I'm so glad I'm here." "When I set sail for England, May 30, 1941. I committed myself to this war, and as long as I feel I can possibly do the job, I'll stay with it to the finish." "After all, just waiting is part of war, and the causes of such periods are not my worry or responsibility." "It seems so remarkable when men who were moribund five days ago are eating and smiling that the nurses almost get slap happy at the relief and joy of it."

Here is what may well be the voice of the Women's Army Corps: "This individuality the Army cannot destroy—nor does it seek to do so. Its sole interest is to obtain from each a required reaction to a stimulus, which collective response is designed to lead to victory. But the concepts of duty and service are our greatest acquisitions. The whys and wherefores of existence itself undergo serious consideration, and the importance to self and society of unselfish living is rated higher and higher . . . I had a chance to leave the Corps . . . But I had other ideas, and have them still. I'm becoming a more tolerant woman, a more conscientious citizen with truer ideals of duty and corresponding privilege. Maybe a lot of Wacs wouldn't say it quite that way; maybe a lot of Wacs wouldn't say it at all; but a lot of Wacs are sure thinking it!"

If anyone is interested in a particular nurse, Wac, or Red Cross worker and is wondering what all the upturning of life and habits and thoughts that War is doing to her, pride, comfort, and reassurance will be found in *With Love, Jane.*

—JULIA C. STIMSON, *Major, Army Nurse Corps, Retired.*

THE ROAD TO RECOVERY

A Study of Convalescent Homes Serving New York City. Prepared by Elizabeth G. Gardiner and Francisca K. Thomas for the Committee on Convalescent Care Practice. 197 pp. Hospital Council of Greater New York, 370 Lexington Avenue, New York 17, N. Y. 1945. No charge. Copies can be procured from publishers.

This book reports a survey of the convalescent homes with special emphasis on their admission and discharge policies, facilities and personnel, relation to referring agencies and financial problems. Convalescence is defined as the period restricted to the recovery of those patients who have been under medical supervision.

Topics selected for investigation were those which offered a factual basis for promoting a community-wide plan of action, and forty-nine facilities for convalescents were chosen for the study. Most of the data relate to the year 1940.

A study of the present situation with its changing aspects and a general plan for meeting the situation begin the report. In nine chapters the findings are set forth in paragraphs and statistical table. The tenth chapter carries the recommendations which fall into three groups: measures requiring community action, measures dependent upon action taken by the homes themselves and measures calling for action by the referring agencies. The responsibilities of a representative committee in initiating the recommended reformation and those of each person and agency involved in the entire program of convalescent care are set forth in clear and concise detail.

An appendix lists the names of the homes included in the study and a selected bibliography.

—Helen L. Woodworth, R.N., *Director of Nursing Service, Visiting Nurse Association, Pasadena, California.*

TEXTBOOK OF OBSTETRICS

By Henricus J. Stander, M.D., F.A.C.S. 1277 pp. D. Appleton-Century Co., New York, 3rd revision. 1945. $10.00.

This third revision of Stander's textbook, presenting the Ninth Edition of Williams Obstetrics, will continue to be one of the standard books on the subject. It covers the art and science of obstetrics quite completely. Besides having been brought up to date by the addition of recent advances, the general plan has been changed in the revision by presenting the subject in sections and subheadings instead of chapters. Both clinical and x-ray pelvimetry are adequately discussed, as well as the use of the sulfonamide drugs and penicillin in the complicating infectious diseases and in puerperal infections. It is extremely well illustrated. It is my opinion that "streamlining" would have made it a better textbook for teaching, but it is highly recommended for reference and study.

—William V. Cavanagh, M.D., *New York, N. Y.*

AT HIS SIDE: THE STORY OF THE AMERICAN RED CROSS OVERSEAS IN WORLD WAR II

By George Korson. 322 pp. Coward-McCann, Inc., New York. 1945. $2.75.

This book literally lives up to its title. Packed with facts, it is alive with the experiences of the Red Cross workers from Iceland to the Ascension Island, through Africa, through the misery of the Italian peninsula campaigns, and into the horrors of New Guinea.

The foreword carries the statistical facts: that the American Red Cross followed the war from the first, giving aid to civilians in all invaded countries and to refugees everywhere; that it raised fabulous sums ($420,000,000 from 1942 through 1944); that it secured 6,500,000 volunteers, recruited nurses and trained nurse's aides; that it produced hundreds of millions of articles of supply—dressings, clothings, kits; and that it collected the greatest gift of all, blood plasma that saved the lives of so many.

Starting his story from Hawaii on December 7, 1941, the author follows the path of the 7,000 trained Red Cross workers who shipped overseas and circled the globe with our troops. Employing a method of reporting that was first used in this war by the Russian newspaper writers, describing each situation in terms of the individual, the author holds our interest through 300 pages of dramatic experiences.

—Florence Miner Farr, *Brookside, New Jersey.*

SOCIOLOGY APPLIED TO NURSING

By Emory S. Bogardus, Ph.D., and Alice B. Brethorst, Ph.D., R.N. 312 pp. W. B. Saunders Company, Philadelphia, second edition, 1945. $2.50.

This book was designed to help nurses understand those sociological facts and principles which influence the emotional and physical lives of their patients, and to appreciate those principles related to the development of all nursing.

Written primarily for use in schools of nursing, it contains units on human nature and personality, the modern family, the modern community and the individual in sickness. Summaries, questions, exercises and bibliographies are included in the units.

The content is so broad in scope that it becomes to some degree a summary of information to which students are exposed in the standard program of studies. Though it could be used to advantage as a reference in sociology if such is given as a separate course of study, emphasis however should be placed on units dealing with the modern family and community, and on chapters dealing with medical-social problems and community health agencies.

—Elizabeth Lynch Sewell, R.N., *Long Island City, N.Y.*

THE NAVAHO DOOR

By Lt. Comdr. Alexander H. Leighton, M.C., U.S.N.R., and Dorothea C. Leighton, M.D. 149 pp. Harvard University Press. Cambridge, Mass. 1945. $4.00.

This book gives a warm and rich account of understanding a people who are separated from us by language, color, and a whole way of life. The authors, who are psychiatrists,

stated that their purpose was to try to understand the Navahos' way of looking at things and to compare their points of view with our own and that of people brought up like ourselves in average American communities.

The description of the Navaho's rich ceremonial life is fascinating, particularly the studies of the Navaho healing institutions and facilities which are the "heart" of this book. One is left with a great desire to serve these interesting American Indians but even more important is the challenge to the white race to be reliable, honest, and willing to understand —characteristics which are essential if we as a nation are to meet our world wide problems of today. Through the vivid descriptions and beautiful illustrations of ceremonials, mode of living, of dress, and of family life, the reader is captivated and learns imperceptively methods of appoach and teaching to a group of people whose language and customs are different from ours.

The Navaho Door has a most beautiful conclusion showing the love and loyalty of a minority group for his country—yours and his —of his willingness to serve his country in war, and his great trust in the White Father and in this great American country for a fair deal and a protection of his rights.

—Rosalie I. Peterson, *Nurse Officer, U. S. Public Health Service, Washington, D.C.*

THE DIET MANUAL FOR HOME NURSING

By Marie V. Krause, M.S., and Eleanora Sense, M.S. 218 pp. M. Barrows and Co., Inc., New York, N. Y. 1945. $2.00.

The book, divided into three parts, interprets simply and clearly both the adequate and special diet. Part One is concerned with the importance of the foods that make up the adequate diet. Part Two gives an explanation of the more common special diets as well as practical menu suggestions. The authors try to remove the stigma, attached to special diets by the lay person, by explaining that the special diet is an adaptation of the diet to meet the special needs of the patient. Part Three gives detailed instructions on the preparation of foods and recipes, showing how these foods can be palatable as well as nourishing.

This book will be useful to a great many people because it is so easily read and understood. Mothers will find the book helpful not only in understanding the special diet but also in feeding all members of the family to keep them healthy. Public health nurses and teachers of home nursing classes will find it a good guide for teaching normal nutrition and special diets.

—Mrs. Evelyn A. Leatham, *Nutritionist, The Public Health Nursing Association of Pittsburgh, Pa.*

STATISTICS OF MEDICAL SOCIAL CASEWORK IN NEW YORK CITY: 1944

By Ralph G. Hurlin. 21 pp. Russell Sage Foundation, New York, 1945. 25 cents.

Public health nurses will be interested in the careful definitions of terms used in these statistics of Medical Social Service departments in 9 municipal and 44 voluntary hospitals. The median number of professional workers per department was 4.6 and the total number employed in an average month by the 53 departments was 355. The median number of active cases monthly per worker was 72 in the municipal and 50 in the voluntary hospitals. The median number of casework interviews monthly per active case was 4.1 in the municipal hospitals and 3.5 in the voluntary hospitals. Telephone interviews are included in the above figures. The inclusion of telephone interviews in public health nursing has been discussed often but the NOPHN Records Committee still considers that telephone interviews should not be counted as visits. However, in the medical social work statistics 24 percent of the total case work interviews in the municipal hospitals were by telephone and 31 percent in the voluntary hospitals. This publication is available on loan to NOPHN members from the National Health Library. It offers interesting suggestions to those compiling public health nursing statistics.

D.E W.

NATIONAL HEALTH AGENCIES

Report of a Survey with Special Reference to Voluntary Associations. By Harold M. Cavins. 251 pp. Public Affairs Press, American Council on Public Affairs, 2153 Florida Avenue, Washington 8, D.C., 1945. $3.00.

This report of a survey of representative voluntary professional and promotional health agencies answers many of the questions about how and why such agencies came into exist-

ence. They were studied in relation to the scientific, governmental, social, educational, and economic developments of the period and they seem to be the result of American faith in private initiative, interest in mass education, and flair for organization.

Although much of the material is covered rather superficially, the book is very well documented and interestingly written. It will help the reader, especially the beginner in public health, understand the background and possibly the future of the voluntary health agency.

One might question the author's selection of representative agencies and the failure to recognize the promotional functions of the NOPHN and the contributions of lay members to this organization.

A directory of the major national health agencies is included but, as a directory, the Social Work Yearbook would seem to be a better investment for public health nurses.

—ELLA E. MCNEIL, *Professor of Public Health Nursing, School of Public Health, University of Michigan, Ann Arbor, Michigan.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

INDUSTRIAL HEALTH

THE ADJUSTMENT OF THE NERVOUS VETERAN IN INDUSTRY. By Meyer Brown, M.D., Ph.D. Industrial Welfare Department, Zurich Insurance Companies, 135 South La Salle St., Chicago 3, Ill. Nov. 1945. 52 pp. Will be sent to anyone writing on company or other official stationery for 10 cents to cover postage and mailing costs.

COURSES IN CLINICAL NURSING FOR GRADUATE NURSES. Basic Assumptions and Guiding Principles—Basic Courses, Advanced Courses. Pamphlet No. 1. Prepared by Special Committee on Postgraduate Clinical Nursing Courses. National League of Nursing Education, 1790 Broadway, N.Y.C. 19, N.Y. 1945 12 pp. Single copy: 25c.

INDUSTRIAL MENTAL HEALTH: A ROUNDTABLE DISCUSSION. The National Committee for Mental Hygiene, Inc., 1790 Broadway, New York 19, N.Y. 1944. 19 pp. Single copy: 15c.

INDUSTRIAL SAFETY TOMORROW. Prepared by the Committee on Postwar Industrial Safety. National Safety Council, Inc., 20 N. Wacker Drive, Chicago 6, Ill. 1945. 16 pp. Free.

SICK-LEAVE PROVISIONS IN UNION AGREEMENTS. Bureau of Labor Statistics Bulletin No. 832. Write Superintendent of Documents, U. S. Government Printing Office, Washington 25, D.C. 1945. 7 pp. Single copy: 5c.

UNION SERIES 1945. Women's Bureau. U. S. Department of Labor. Washington, D.C. Free.

No. 1—Seniority.

No. 2—Rate for the job.

No. 3—Union Provisions for Maternity Leave for Women Members.

GENERAL

A SURVEY OF EL DORADO, KANSAS, AS A POSTWAR MEDICAL CENTER. By Graham L. Davis. American Hospital Association, 18 E. Division St., Chicago 10, Ill. 1945. 23 pp. Free.

WILL NEGROES GET JOBS NOW? by Herbert R. Northrup, Ph.D. Public Affairs Pamphlet No. 110. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York 20, N. Y. 1945. 32 pp. Single copy: 10c.

SOCIAL SECURITY. A statement by the Social Security Committees of American Life Convention, Life Insurance Association of America, and the National Association of Life Underwriters. May be procured at any one of the above organizations at the following respective addresses: 230 N. Michigan Ave., Chicago 1, Ill.; 165 Broadway, New York 6, N. Y.; and 11 West 42nd St., New York 18, N. Y. February 1945. 57 pp.

REHABILITATION

SOLDIER TO CIVILIAN. By George K. Pratt. McGraw-Hill Book Company, New York, N. Y. 1944. 233 pp. $2.50.

This book deals with some of the problems of adjusting to family and community life faced by the returned soldier or sailor.

WHAT THE SOLDIER THINKS—POST-WAR PLANS OF THE SOLDIER. Research Branch, Information and Education Division, Army Service Forces. Copies may be obtained by writing to Director, Information and Education Division, Army Service Forces; Attn. Chief, Research Branch, Room 2 E 562, The Pentagon, Washington 25, D. C.

Public Information Tips

Thousands of communities throughout the country are making extensive plans for observing Know Your Public Health Nurse Week, April 7-13. NOPHN will appreciate hearing about these plans so they can be mentioned in the Magazine and in the next issue of "Phn," quarterly news bulletin which is sent to all NOPHN agency and individual members. *E. W.*

THE Steering Committee for Know Your Public Health Nurse Week is very happy to announce that 25 people have accepted honorary membership on the Sponsoring Committee: Mrs. Margaret Culkin Banning, Mrs. August Belmont, Edgar Bergen, Bing Crosby, Alfred W. Dent, Mrs. LaFell Dickinson, Martha M. Eliot, M.D., Clifton Fadiman, Walter S. Gifford, Helen Hayes, H. J. Heinz, Walter Lippmann, Henry R. Luce, Dorothy Maynor, Basil O'Connor, Thomas Parran, M.D., Leo Perlis, Mrs. Franklin D. Roosevelt, Mrs. Gerard Swope, Channing H. Tobias, Mrs. Harry S. Truman, Mrs. DeForest Van Slyck, Thomas J. Watson, Ray Lyman Wilbur, C.-E. A. Winslow, Dr.P.H.

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With the slogan, "A part-time nurse for every purse and free when needed," the Board of Directors of the Community Health Service, Grand Rapids, Michigan, began on January 15 an extensive educational campaign to make everybody in the community aware of the Service and how to use it. The campaign began with a nine o'clock brunch for members of the Board who later took part in a canvass of business, professional, and public buildings and factories. More than 1,600 individuals were polled in this way at the very start of the campaign. Grand Rapids newspapers gave and are continuing to give considerable space in their columns. The campaign will continue with interviews over radio stations, talks before community and civic groups and will culminate with observance of Know Your Public Health Nurse Week, April 7-13. The Board of Directors plans to extend the poll to cover the majority of clubs in the community. Such an educational poll is one of the recommended "Action Ideas" for Know Your Public Health Nurse Week. Of particular interest to other boards of directors is the information that the Community Chest has increased the Community Health Service's allowance for publicity in order to pay for necessary expenses including a special leaflet given to all people interviewed.

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Although not getting off to such an early start as Grand Rapids communities, all sections of the country are enthusiastically making plans to observe Know Your Public Health Nurse Week. In fact, interest is so keen that the Steering Committee for the "Week" is being bombarded by requests for radio transcriptions, trailers for motion picture theaters, and many other publicity aids which require considerable funds to finance. The Committee is very aware that these aids would be valuable assets to interpretation and wishes it might produce them. But no funds are available—at least this year. The Steering Committee has only those funds it has been able to raise from outside sources. In spite of a limited budget, the Steering Committee feels that if the "Action Ideas" for the "Week" are carried out in as many communities as possible, a very valuable job of interpretation will have been done.

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Information of significance to public health nursing was revealed by a recent questionnaire sent by the Crowell-Collier Publishing Company to 1,825 Reader-Reporters of the *Woman's Home Companion* to determine to which sources mothers turn for help in the physical care of children. Of the 909 mothers replying, 586 reported they knew that visiting nurse service was available in their communities. Fourteen percent of these mothers reported they used this service occasionally and 5 percent regularly. Additional information revealed by answers to the questionnaire included: 78 percent of all the Reader-Reporters were interested in having more articles on how to solve problems of children's health; books and newspapers are more popular as guides to the physical care of children in families of higher incomes and city folks, but radio programs are relied on more by the less wealthy (both groups seem to rely equally upon magazines and leaflets); most of the mothers wanted help with the physical care of children between 2 and 12 years old; the wealthy are just as bewildered as those less well off about problems connected with children's behavior and physical care. This information should prove helpful to public information committees because the more closely publicity material is related to these interests the more effective the interpretation.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

FILM STRIP PREVIEW AT MLI TEA

The new sound *film strip*, "Your Friend, the Public Health Nurse," produced by the Metropolitan Life Insurance Company in collaboration with the NOPHN, was previewed at a tea at the Visiting Nurse Service of New York on January 15. Members of the boards and staffs of local agencies and the staffs of MLI and NOPHN were guests of MLI on this occasion.

Designed to help the average citizen to understand and use available public health nursing service, this film strip is appropriate as well for showings to medical and nursing groups, especially schools of nursing. It will be helpful also in the observance of Know Your Public Health Nurse Week, April 7-13. A film-strip projector and a turntable running at 33⅓ revolutions per minute are required for showing this single-frame 35 mm. film strip. The ordinary phonograph and motion-picture projector cannot be used. Sound strip machines can sometimes be borrowed from community agencies or business concerns. Or if no sound strip machine is available, the strip can be run on a silent projector and the sound reproduced by having the script read aloud.

The film can be borrowed without rental fee or transportation charge from MLI, 1 Madison Avenue, New York 10, N.Y. It is not for sale, but in special instances can be retained for showing over an extended period of time. Projectors and turntables can be purchased from the company. Write MLI for further information.

CONVENTION MANAGER APPOINTED

Marion M. St. Clair has been appointed convention manager for the Biennial Convention of the three national nursing organizations to be held September 23-27 in Atlantic City, New Jersey. Miss St. Clair has a varied business background which includes work on convention arrangements for the Hotel Statler, Washington, D.C., and business analysis and administrative work with the Office of Price Administration.

As manager, she will act as secretary of the Headquarters Convention Committee of the ANA, NLNE, and NOPHN, will revise the Convention Procedure Manual, plan all details for meetings, and work closely with the state convention arrangements committees on all matters relating to general arrangements. Responsibility for convention arrangements rotates biennially between the national organizations, this year resting with the NOPHN. Miss St. Clair's headquarters will be the NOPHN office, 1790 Broadway, New York City, until midsummer when she will take up offices at Atlantic City.

Registration fee for the Convention will be $2.00. Further announcements regarding hotels, et cetera, will be made shortly.

BOARD MEMBER ACCEPTS ARC POST

Mrs. Walter Lippmann, formerly national director of the Red Cross Volunteer Nurse's Aide Corps, has recently been elected secretary of the American Red Cross. Under Mrs. Lippmann's direction, the Red Cross Volunteer Nurse's Aide Corps expanded from 364 members in July 1941 to more than 211,000 at the time of her resignation. Mrs. Lippmann is a member of the Board of Directors of the National Organization for Public Health Nursing.

WHAT MEMBERS AND FRIENDS ARE DOING

Jean E. Sutherland has been appointed professional consultant for the new Nurse Counseling and Placement office of the United States Employment Service at 119 West 57th Street, New York City. She will be responsible for technical supervision of the employment office staff to insure professional standards in nurse placement, and for maintaining liaison with associations of professional and practical nurses and with medical groups. For the past two and one half years Miss Sutherland has been nurse consultant for the War Relocation Authority in Washington, D.C., in charge of recruiting and staffing of nurses in Relocation Center Hospitals. Prior to that, she was a supervisor on the staff of the VNS of New York . . . *Doris L. Robinson* has been appointed director of the Bureau of Public Health Nursing, San Francisco Department of Public Health . . . *Ruth Rives*, formerly district supervising nurse at Glen Falls, New York, has been appointed assistant director of the Division of Public Health Nursing, New York State Department of Health. . . . The following nurses have been released from military service and reinstated to positions with the Metropolitan Life Insurance Company: *Joan L.*

Collette, Jersey City, New Jersey; *Alice J. Grady,* Cohoes, New York; *Jean Hamilton,* Jersey City, New Jersey; *Josephine Hogan,* Malden, Massachusetts; *Helen King,* Atlanta, Georgia; *Gertrude Mills,* Harvey, Illinois; *Marguerite Murray,* Hempstead, Long Island; *Mrs. Esther Lutz Parks,* Washington, Pennsylvania; and *Margaret Richardson,* Norristown, Pennsylvania. . . . *Gertrude S. Banfield* of the American National Red Cross Nursing Service represented that organization at the first meeting since 1937 of the Nursing Advisory Committee of the League of Red Cross Societies in Geneva, Switzerland, February 6, 7, and 8. One of the Committee's responsibilities is to aid in the formulation of programs for the nursing division of the League in its preparations to assist member societies in development of nursing programs.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Louise L. Cady	Atlanta, Ga.—Feb. 11
Ruth Fisher	Poughkeepsie, N.Y.—Feb. 18
Mable Grover	Gary, Ind.—Feb. 18-March
Ruth Houlton	Washington, D.C.—Feb. 5, 6
Sarah A. Moore	Chicago, Ill.—Feb. 20-23
Eleanor Palmquist	Newark, N. J.—Feb. 1
	Boston, Mass.—Feb. 5
Louise M. Suchomel	Baltimore, Md.—Feb. 6-8
	Waterbury, Conn.—Feb. 26
	Staten Island, N.Y.—Feb. 28
Edith Wensley	Bridgeport, Conn.—Feb. 19

In January, after the magazine went to press, Edith Wensley visited Westfield, N. J., and spoke at the annual meeting of the District Nursing Association. Dorothy Rusby, of the AWCS staff, visited Kinston, N.C., and Newport News, Va.

TUBERCULOSIS SCHOLARSHIP GRANT

The tuberculosis nursing scholarship grant made in 1945 by the National Tuberculosis Association to the National Organization for Public Health Nursing will also be available for 1946. This scholarship fund of $10,000 is given to further the education of teachers and supervisors in tuberculosis nursing.

Preference will be given to nurses with experience in tuberculosis nursing and in supervision, who meet other requirements set up by the Tuberculosis Nursing Scholarship Committee, of which Alta E. Dines, director of the Division of Educational Nursing, Community Service Society, New York City, is chairman.

Applications for this scholarship must be filed not later than May 31, 1946.

Inquiries may be sent to Mrs. Louise Cady, tuberculosis nursing consultant, National Organization for Public Health Nursing, 1790 Broadway, New York 19, New York.

ORTHOPEDIC SCHOLARSHIPS AWARDED

During the past year NOPHN and NLNE scholarships, available through funds from the National Foundation for Infantile Paralysis, have been granted to ten graduate nurses for preparation for supervisory and teaching positions.

Nurses who received NOPHN awards are: Ruth Aushman and Ita K. McDermott, VNA, Brooklyn, New York; Thelma Brown, VNA, Chicago, Illinois; and Ida Mae Walker, New York City. Four NOPHN awards are pending.

Nurses who received NLNE scholarships are: Anne Irene Adams, Syracuse (N.Y.) University Hospital of Good Shepherd; Miriam Jane Crouch, Western Reserve University Hospital, Cleveland, Ohio; Ruth B. Gishler, Metropolitan Hospital, New York, N.Y.; Emily Francine King, University of Oregon School of Nursing, Portland, Oregon; Anne Charlotte Hall, Massachusetts General Hospital, Boston; and Nellie M. Van Dyke, Touro Infirmary, New Orleans, La.

Applications for awards may be submitted at any time to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, N.Y.

TELEGRAM! WATCH FOR URGENT CALL FOR INFORMATION ABOUT PERSONNEL PRACTICES STOP QUESTIONNAIRES GOING OUT SOON STOP ANSWER PROMPTLY

A review of personnel practices in public health nursing agencies and development of standards on personnel policies is urgently needed at the present time. A special NOPHN committee is now studying personnel policies in nursing and related fields. They would like to complete this work and be ready with recommended standards as early as possible. This year, you will note, a large part of the Yearly Review is devoted to the subject of personnel policies. You will receive your questionnaire within a very short time. Will you answer and return it to the NOPHN office within three weeks from the date received? This information is needed before the committee can proceed with its work. Help us to give satisfactory answers to mail inquiries about salaries, hours of work, cars, and uniforms which pour into this office daily by complying to this request.

NEWS AND VIEWS

On National Nursing

OPENINGS IN USPHS

Appointments to fill vacancies in the Reserve Corps of the United States Public Health Service are now being made, and examinations for Regular Corps appointments will be held in April and May, Surgeon General Thomas Parran announced on January 17.

Physicians, dentists, and nurses are needed immediately for duty in hospitals, in the Tuberculosis and Venereal Disease Control programs, and in other activities of the Public Health Service.

Pay and allowances, established by law, are identical with those for medical officers of the Army. All travel expenses, including travel to first station, are paid by the Service.

In announcing the recruitment campaign, Dr. Parran stated: "For the physician, the dentist, and the nurse, the Public Health Service is unique in the variety of opportunities it offers. Not only does the person have the opportunity for outstanding service to the nation in the growing field of public health, but the opportunities for professional growth and development are almost limitless. There is clinical work in Public Health Service hospitals throughout the country. The importance of medical research is being emphasized today more and more and in the Public Health Service, research opportunities exist in both laboratory and the field. Institutional, public health, and administrative work is offered nurses. Whether a professional person is embarking on his career, or has already elected the field in which he wishes to specialize, the Public Health Service, I sincerely believe, offers him much that he is seeking."

Appointments to the Reserve Corps are made on a basis of review of data furnished by the applicant. Physical examination is required.

Regular Corps appointments require appearance before a Board, and a written professional examination. Dates and places for the examination will be announced shortly.

The Service pointed out that a person receiving an appointment in the Reserve Corps immediately, may, if he desires, take the examination for the Regular Corps at the time it is held.

Those interested in either immediate appointment in the Reserve Corps, or in taking the examination for the Regular Corps, should request application forms of the Surgeon General, U. S. Public Health Service, Washington, D.C., Federal Security Agency.

NURSES IN VETERANS ADMINISTRATION

Under Public Law No. 293, which became effective January 3, 1946, a Department of Medicine and Surgery was created in the Veterans Administration, an integral part of which will be a Nursing Service under the supervision of a director. The law also establishes a new salary scale for nurses commensurate with training and experience and provides for increased professional and educational opportunities for VA nurses.

Regulations governing professional personnel will be set up by VA to replace Civil Service rules which heretofore have governed its personnel. Pending establishment of new procedures and standards, nurses, physicians and dentists now on duty with VA will be continued in their present Civil Service positions. The new salary scales are as follows, pay increases being granted with length of service within these limits:

Assistant directors — $5,180-$6,020 (supervisor, branch office and consultant in special field)

Senior grade—$4,300-$5,180 (chief nurse, large hospital; assistant supervisor, branch office)

Full grade—$3,640-$4,300 (assistant chief nurse, large hospital; chief nurse, small hospital)

Associate grade—$2,980-$3,640 (instructor; head nurse)

Junior grade—$2,320-$2,980 (staff nurse)

Promotions to higher grades will be based upon performance and interest in nursing and nursing education. VA nurses will be subject to the 5% salary deduction and receive retirement benefits under the Civil Service Retirement Act.

Appointments will be made directly to the Department of Medicine and Surgery upon the recommendation of the Chief Medical Director. For qualification requirements, application forms, and other information, consult the manager of the nearest VA Hospital, Regional Office or Center, or write to: Chief Medical Director, Veterans Administration, Washington 25, D.C. Attention: GAM.

PUBLIC HEALTH NURSING

MISS GOODRICH HONORED

Over 200 prominent educators, scientists, and leaders in nursing honored Annie Warburton Goodrich, organizer and first dean of the Yale University School of Nursing, at a formal birthday dinner, February 2, in New Haven, Connecticut. A leader in her profession, known throughout the country and the world, and holder of the Army Distinguished Service Medal, Miss Goodrich passed her eightieth birthday on that day. Outstanding in her career was her direction of the Yale University School of Nursing, from the time of its establishment in 1923 until her retirement in 1934. Latest result of her work at Yale is the accreditation of the school's basic program by the NOPHN and the NLNE. Its graduates are now qualified for staff level positions in public health nursing agencies which provide direct nursing supervision.

MATERNITY SERVICE RESTORED

Maternity nursing services to policyholders of the Metropolitan Life Insurance, reduced during the war, have been reinstated as of January 1, 1946 to the following extent: (1) one antepartal visit per month is permitted on all normal cases (2) two visits to the mother and baby are authorized for instruction and demonstration bath for patients returning from hospital after sixth day. Other regulations outlined in the Nursing Manual remain in effect. As in the past, the company does not authorize and will not pay for antepartal nursing visits when the local health department includes this service in its program and is prepared to assume this added load.

CLEVELAND SEEKS BUILDING FUND

A campaign for funds to house the Cleveland Visiting Nurse Association in a new building was launched last November, with a goal of $204,000 for land, building, and equipment. The VNA has served Cleveland for 43 years, pays approximately 135,000 visits to the sick annually. In her letter soliciting financial aid from friends of the Association, Mrs. R. L. Ireland, Jr., chairman of the Building Committee, stated that the ideal of the visiting nurse is "to leave the patient soothed in mind and body, to teach the family to cope with the difficulties of illness, and to sow the seeds of future health."

From Far and Near

● The Wisconsin Bureau of Personnel, Madison 2, Wisconsin, announces vacancies in the position of advisory public health nurse, with salary range of $200-$260. Duties consist of giving advisory service to locally employed public health nurses and teaching public health nursing techniques. Certification in the state is required and two years' experience, one of which is in a supervisory capacity, is desirable. Applications must be filed with the Bureau on or before March 15.

● "A Healthy Home in a Healthy Community: Health Education and Health Services" supplants last year's National Negro Health Week slogan, "A Healthy Family in a Healthy Home." The Week's thirty-second observance, which occurs this year, will take place March 31 to April 7. An official Health Week poster, bulletin, and school leaflet will be supplied for early distribution to agencies, institutions, and groups who wish to use these publications in the promotion of the Week. Write National Negro Health Week Committee, U. S. Public Health Service, Washington 14, D.C.

● The 28th Annual Meeting of the American Dietetic Association will be held at the Netherland Plaza, Cincinnati, Ohio, October 14 through 18, 1946.

Chemotherapy in Tuberculosis—Rest remains the fundamental remedy for tuberculosis is the conclusion of H. Corwin Hinshaw, M.D., and William H. Feldman, M.D., in a discussion of chemotherapy in tuberculosis, *Bulletin* of the NTA, October 1945. In the opinion of the writers, no drug now available is likely to supplant rest completely, and it would be unwise for a patient with tuberculosis to discard the known benefits of rest treatment for the uncertainties of treatment with a new drug.

Efforts to develop an effective medicinal treatment for tuberculosis have been underway since this disease was first recognized, and in the present day many of the drugs used successfully in treating other conditions have been tried, not too successfully, in the treatment of tuberculosis. Hope that sulfone drugs (promin, diasone, and promizole), effective in arresting tuberculosis in the highly susceptible guinea pig, might be of value in the treatment of tuberculosis of human beings, have been somewhat dimmed by recent experiments. Most sulfone drugs have a more toxic effect on humans than on guinea pigs, and this restricts the amount of treatment which can be given to patients with comfort and safety. There is some reason to believe also that some sulfone drugs are altered in the human body and become ineffective. They may be of value in the treatment of certain unusual varieties of human

tuberculosis, but such use has not progressed beyond the experimental stages. Penicillin appears to have no effect on tuberculosis in either guinea pigs or in man, but other substances may be extracted from living micro-organisms which can suppress the growth of bacteria which produce disease. Streptothricin and streptomycin are two of the substances in this group which have been experimented with in the treatment of tuberculosis. Both are derived from a soil-inhabiting fungus and are effective in restraining the growth of tubercle bacilli in test tubes. Streptothricin is somewhat toxic to guinea pigs and is not effective in restraining the development of tuberculosis in these animals. Streptomycin is well tolerated by guinea pigs and does inhibit the development of experimental tuberculosis in these animals. Experiments have shown that this substance will eradicate well established tuberculosis in about a third of the guinea pigs treated, and in the remaining two-thirds of the animals treated, the disease will improve to a stage which can be regarded as arrested tuberculosis. Adequate study of streptomycin in the treatment of human tuberculosis remains to be accomplished.

Should an effective drug be developed, Drs. Hinshaw and Feldman assert "it is certain that sanatoriums will be among the first to make use of such treatment and will become the most important centers for such treatment." In the meantime, they advocate adhering to the well established methods of treatment. And, "when patients and their relatives become confused they should seek the advice of their physician who has access to medical journals and also can secure information at first hand." Helpful literature and advice are also available through health department and tuberculosis associations.

Sodium Fluoride Treatments—That the topical application of sodium fluoride to the teeth of school children is as effective in inhibiting dental caries the second year after treatment as during the first is reported by Dr. J. W. Knutson and Dr. W. D. Armstrong in *Public Health Reports* for September 14, 1945. Findings of the study, undertaken by the authors in Minnesota over a two-year period, indicate that such treatments lower the attack rate of dental caries approximately 40 percent and provide this degree of immunity for at least two years. The report is a continuation of an earlier one, published in the same periodical, November 19, 1943, in which data were given on the incidence of dental caries in the permanent teeth of two groups of Minnesota children. One group consisting of 289 school children received 7 to 15 topical applications of 2-percent sodium fluoride solution to the teeth in the upper left and lower left quadrants of the mouth. The second group of 326 control children did not receive the fluoride treatments. Fluoride treatments were completed May 1942 and the teeth of both groups of children were re-examined at yearly intervals thereafter. Analysis of the data for the year ending May 1943 indicated that (1) the number of previously undecayed teeth attacked by caries during the study year was approximately 40 percent less in fluoride-treated than in untreated teeth and (2) the number of additional tooth surfaces attacked in previously carious teeth was less but not significantly less in treated than in untreated carious teeth. By May 1944 re-examinations showed that initial caries attack on fluoride-treated teeth continued to be approximately 40 percent less than on untreated teeth; the number of additional tooth surfaces attacked in previously decayed teeth was over 20 percent less in treated than in untreated carious teeth. Following this initial or pilot study additional studies on the caries-inhibiting effect of topically applied fluorides will be undertaken. (*See also* PUBLIC HEALTH NURSING, October 1944, p. A 11).

Trichinosis—The situation today with regard to the control of trichinosis, according to S. E. Gould in the *Bulletin of the New York Academy of Medicine*, November 1945, may be likened to that which prevailed in the dairy industry of this country 30 or more years ago, prior to the general adoption of pasteurization of milk. In other words, the public is not sufficiently protected against or educated to the dangers of this disease.

Man acquires the infection almost exclusively from eating pork containing viable trichinae. The pig acquires the infection primarily from the consumption of bits of raw trichinous pork in uncooked garbage. Approximately 25 percent of the general population in the United States develop trichinous infection during their lifetime, or approximately one person in every four. The infection is subclinical in the majority of cases; at least 5 percent who become infected show signs of illness but only about 1 percent are confined to bed. The mortality rate from clinical trichinosis is 5 to 6 percent.

There is no specific remedy except that of prevention. At the present time in this country, prevention of trichinosis is largely up to the ultimate purchaser or consumer of pork and consists principally in thorough cooking or sufficient heating of the pork and pork products. The Federal government recommends that pork should be boiled at least thirty minutes for each kilogram of weight (2.2 lbs.) Another guide for thick cuts of ham or pork is to cook them one-half hour per pound. All portions of cooked pork should be white. Trichinae may also be killed by freezing, by keeping cuts of pork not exceeding six inches in thickness in a temperature of not less than 5°F. for at least 20 days. This temperature is within the range of home type deep-freeze cabinets.

Three public methods of control are available and practical, according to the author, and sooner or

later the public will demand protection: (1) microscopic inspection of meat from every slaughtered hog (2) cooking of all garbage that is to be fed to hogs and (3) processing of all pork—refrigeration, cooking, smoking, et cetera—to render it free from viable trichinae. Processing, it is stated, is the most practical method. Its cost would eventually be borne by the consumer as in the case of pasteurization.

Promin in Leprosy—Evidence of clinical improvement in a study of 137 leprosy patients at the National Leprosarium in Louisiana treated with promin indicates that it is the treatment of choice for this disease, according to Faget and Pogge in *Public Health Reports*, October 5, 1945.

The average daily dose of promin (a sulfone drug) per patient, including days of rest when no promin was given, varied from 0.4 to 4.6 gm. The dosage was usually started at 1 gm. daily intravenously and gradually increased in an attempt to reach the optimal dosage of 5 gm. daily. The size of the dose depends mostly upon the patient's tolerance to promin, and the present routine consists of daily intravenous injections for 6 days a week in courses of 2 weeks' duration, with 1 week of rest between courses. Since this technique has been adopted toxic reactions have been few and of a minor nature. The week of rest usually allows sufficient time for the hematopoietic system to restore the blood cells lost through the hematolytic action of promin.

The good effects of promin are evident to both doctor and patient. Many patients report improvement in health, appetite, sleep, and less respiratory difficulty, but these symptomatic improvements seem to be secondary to the effect of promin on the disease processes in the body. Promin is only one of a number of drugs which are helpful in healing leprous ulcers, but unlike the other drugs promin seems to bring about definite improvement in leprous nodular lesions and infiltrations.

Promin is not claimed to be a specific remedy for leprosy—that is, it has no direct chemotherapeutic action against the etiologic agent of leprosy—though it has been shown to have a favorable effect in this disease. There is hope that continued scientific research will produce a faster acting, more specific drug. Preliminary studies suggest that diasone has a similar action to promin and further trial may prove that it is a more satisfactory remedy than promin. (For "Trends in Leprosy in the U. S." *see* PUBLIC HEALTH NURSING, March 1945, p. 171.)

Control of Syphilis in Pregnant Women—As a result of the Illinois plan for the control of syphilis in pregnant women under care of general practitioners, instituted under the antepartum blood-testing law which became effective in July 1939, there were 94 percent normal living nonsyphilitic children in the 550 cases in which treatment was started before the end of the fourth month of pregnancy. This is reported by Herman M. Soloway, M.D., in the *Journal of the American Medical Association*, October 13, 1945. His study covers the outcome of 1,448 cases of syphilitic pregnant women under the care of 1,087 private physicians. The treatment recommended consists in a weekly muscular injection of a bismuth compound throughout the term of pregnancy and eight to ten intravenous injections of an arsenical, with an occasional four-week rest period. Pregnant women were found to tolerate antisyphilitic treatment as well if not better than nonpregnant women. Not one fatality was reported as the result of the treatment. Although interpretation of serious treatment reactions by so many practitioners is difficult, 8 "serious" reactions were reported and mention was made of 13 others which were not recorded.

The Illinois antepartum blood-testing law provides that all physicians attending pregnant women must submit specimens of the patients' blood for serologic examination to a state or an approved private or hospital laboratory. If positive, a copy of the report is submitted by the laboratory to the office of the Division of Venereal Disease Control. The central registry is then checked to see if the case has been reported by the physician. If the patient is not receiving treatment, a venereal disease investigator, nurse, or public health physician gets in touch with the patient, with the approval of the attending physician, and every effort is made to place and keep her under treatment throughout her term of pregnancy. Public health physicians, nurses, and lay investigators made 740 investigations each year in order to have about 300 cases reported, placed, and kept under antisyphilitic treatment throughout pregnancy as well as to check the child's blood after two months of age.

The author believes that the Illinois Law offers an excellent method of case finding. He concludes, however, that "educational programs on all phases of the cause, spread, and cure of syphilis are greatly needed for the general public and midwives, and the general practitioner is in need of special education."

Malaria by Transfusion—The Bulletin of the U. S. Army Medical Department, October 1945, warns against the use of blood for transfusions from individuals who have or recently have had malaria. The number of cases of malaria in Army personnel acquired by transfusion with infected blood is believed to be very small, undoubtedly because of the careful selection of donors. Most stations collecting blood do not accept as a donor any individual with a history of malaria, or in some instances those with a history of residence in an endemic area. Others have accepted individuals whose last attack of malaria was 12 to 15 years in the past,

in instances where greater restrictions would not permit an adequate supply of blood for immediate transfusion. "For practical purposes," according to the *Bulletin*, "blood is safe for transfusion when three years have elapsed since a last attack of *vivax* malaria was experienced and no suppressive drugs used in the interval. A period of one year of freedom from symptoms is sufficient for infections with *Plasmodium falciparum*. Individuals with a history of quartan malaria should never be accepted as donors."

Pediculosis Capitis—Its efficiency as a lousicide and its availability make benzyl benzoate emulsion, 25 percent, an excellent treatment for *pediculosis capitis*, Dr. Joseph G. Molner reports in the *American Journal of Public Health*, December 1945.

The suggested treatment is as follows:

1. The hair must be carefully shampooed to remove all oil and dirt. Allow the hair to dry.
2. Have the patient sit in a chair and tilt his head slightly backward. Cover his neck and shoulders with a towel or similar cloth, and his eyes with folded pieces of paper towelling.
3. Apply 25 percent benzyl benzoate emulsion with a large absorbent cotten swab or 1½ inch flat paint brush. Apply generously to the hair and scalp, starting preferably from the hair line and working the material against the nap of the hair. The treatment should be applied generously to give assurance of thorough contact of the medication with hair and scalp. Comb the hair in the usual manner.
4. Twenty-four hours later shampoo the hair carefully. Allow the hair to dry—comb and brush thoroughly.

Food Habits—Army authorities report, according to *Nutrition Highlights*, that although it takes three months to set up a new food habit, it takes only two weeks to lose it. Therefore, wives and mothers are urged to serve, before the two-weeks period ends, the milk, salads, vegetables, fruits, cheese and fish which men returning from Army duty are requesting.

Public Education for VD Prevention—Findings of the USPHS Advisory Committee on Public Education for the Prevention of Venereal Disease, which devoted three years of study to their subject, point to certain principles. Venereal disease education is a primary responsibility of official health agencies, to be conducted on an intensive yet sustained basis. Where possible this education should be coordinated with other health educational programs, the total effort to include active community participation. There should be expansion of facilities for training health department personnel who are to engage in educational, informational, casefinding, and related activities. Highlights of the report, published in *Journal of Venereal Disease Information*, December 1945, are:

The report is largely based on proceedings of the National Conference on Postwar Venereal Disease Control, St. Louis, Missouri, November 1944, and on information received from state health officers and large city health departments and from individuals competent in different phases of venereal disease control, education, social hygiene, and social protection.

The St. Louis Report is regarded by the Committee as a comprehensive and thorough study of the problem and basis for the formation of a program for community action for venereal disease control and public education which are so closely interwoven as to be inseparable.

State and local health officers reported need and demand for greater emphasis on venereal disease and social hygiene education in the control problem. They believed that such educational programs should be directed more largely to the population groups with the highest incidence of disease, and that programs should be sustained, intensive, long-range, and an integral part of the general health program. The Committee recognizes the extraordinary need for stimulating a large increase in the recruitment and training of personnel for health education, information, and community work.

The Committee states that local health departments cannot do the total venereal disease control job alone and that they must make sure that all community agencies understand the *whole* job as a preliminary to effective community effort. It approves for local use the methods of education outlined at the St. Louis Conference for special groups such as parents, children, patients, "floaters," and the public. It approves a definite program of cooperation between health departments and the churches. It emphasizes that the health officer has an obligation to work with and obtain the help of law enforcement agencies in support of venereal disease control, and to seek appropriate aid in securing essential laws and regulations. The need for preparation and wide use of suitable films is seen by the Committee and they recommend widest possible use of moving pictures, radio, and other means of mass education. It is pointed out that special effort must be made to reach the "floater" population—people without home ties. Study should be made to find more effective methods of reaching both urban and rural Negroes. It has already been demonstrated that industrial groups can be reached economically and effectively. Health agencies and private physicians should consider providing instruction in personal prophylaxis to people who need it.

The local health officer, it is emphasized by the Committee, must initiate general health education programs in his community, if none exist. If they do exist and are sound and adequate, he is obligated to support and help them. In either case he is responsible for the degree of excellence of all phases of the program.

Sanitary Requirements for School Lunches—The school lunch serves an extremely important purpose from the standpoint of nutrition and practical health education. Such being the case, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association calls attention to certain protective sanitary measures, knowing that the carrying out of these measures will help avoid sickness resulting from contaminated food.

The educational aspects of school lunches, as well as the requirements for an adequate diet, have been presented in the Joint Committee report, "Health Education," (1941 edition), to which the reader is referred. The index of this report furnishes many references to the educational value of the school lunch.

For the purpose of assisting further, the following additional recommendations concerning lunchroom personnel and equipment are made:

1. All persons employed in the lunchroom must be scrupulously clean in person and attire. They should be required to submit to health examinations or procedures which the health or school authorities may see fit to require.

2. The lunchroom and kitchen must be clean and as well equipped as it is possible to expect under the existing circumstances in the particular school, bearing in mind the fact that many schools which are poorly equipped are in very special need of school lunches from the standpoint of nutrition and education.

3. There must be present and in constant use the following equipment: a stove of such capacity as will furnish abundant heat for heating large amounts of water, a sufficient supply of soap or detergent; facilities for washing dishes in water sufficiently hot (115F. to 120F.) to scald them with water over 170F and to allow them to dry without wiping; a supply of dishes and utensils sufficient to permit good practice in the handling of food; a clean, tight cupboard for the storage of dishes and utensils used in cooking; a supply of kitchen linen or its paper substitute great enough to permit sanitary handling of the food; and an icebox or refrigerator. Where no refrigeration is provided, perishable food left over should be disposed of.

4. Food low in price is permissible, but it must not be fermented, decomposed, frostbitten, unclean or of unsanitary quality.

Milk should be pasteurized. If unpasteurized, it should be boiled on the premises. If powdered milk is used, it must be mixed with safe water within an hour or two of the time it is to be used.

Home-canned fruits are safe, but home-canned meats and vegetables may be used only after being boiled for 15 minutes after removing from the can and without tasting. In the absence of satisfactory refrigeration, "leftovers" are never to be carried over to the next day; food prepared must be eaten, sent home with the children, or put in the garbage the same day it is prepared.

Day-old products are not to be used if there is any ingredient which is capable of spoilage or fermentation. This precaution is particularly needed with products containing cream fillings, meringues, custards or non-acid dressings, such as salads made with mayonnaise, Hollandaise cream or cooked dressing, for example, potatoes, chicken, fish, eclairs, cream-puffs or other cream-filled bakery goods; hash or other ground and left-over meat dishes, except smoked or cured meats.

5. The housekeeping of the lunchroom and the kitchen must be above criticism. Particular attention should be given to the exclusion of flies, rats, mice, roaches and other vermin. Food must be kept in closed, dust-proof and vermin-proof containers. Similar containers must be provided for disposal of garbage. Garbage should be wrapped if local ordinances so provide.

6. The personnel and equipment must be under the daily supervision of some responsible person trained for such work—school physician or school nurse, principal or home economics teacher—or representative of the health department—who will have authority to order the abatement of a condition which may be dangerous. This responsible person shall decide whether a lunchroom worker is or is not fit to work on any given day. He shall take into consideration the following points and such others as seem pertinent or necessary to insure safety to the persons eating the school lunch:

a. Is the worker clean in person and clothing? Are hands clean and nails well trimmed and clean? Is the hair covered by an appropriate hair net or cap? Does the worker wash hands immediately before handling food and after use of the toilet?

b. Is there suspicion that the worker is suffering from some communicable disease? If so, he should be examined by a physician or health officer who, in turn, should inform the administrative head of the school regarding the possible transmission of the disease. He should not be permitted to return to work after sickness or absence of undetermined cause until seen by a physician.

c. Is there any skin disease or discharging wound?

d. Is there any infectious disease, such as scarlet fever, in the home of the worker?

e. Does the worker cover the nose and mouth when coughing or sneezing and wash hands after using handkerchief?

f. Does the worker exercise care in handling food, food utensils, and containers?

The close cooperation of lunchroom directors, principals and school physicians or health officers is required if school eating places are to be safe. These people working together can see that sanitary precautions are taken and thus prevent the spread of disease through foods.

THE NUTRITIONAL *Contribution* OF CANDY

LIKE most of the commonly eaten desserts, many candies are made of a number of nutritionally valuable food-ingredients. Hence such candies—in the manufacture of which milk, butter, eggs, fruits, nuts, and peanuts are used—present a nutritional composition which quantitatively as well as qualitatively, on a weight for weight basis, compares favorably with the commonly eaten desserts.

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THE NUTRITIONAL PLATFORM OF CANDY

1. Candies in general supply high caloric value in small bulk.

2. Sugar supplied by candy requires little digestive effort to yield available energy.

3. Those candies, in the manufacture of which milk, butter, eggs, fruits, nuts, or peanuts are used, *to this extent* also—

a) provide biologically adequate proteins and fats rich in the unsaturated fatty acids;

b) present appreciable amounts of the important minerals calcium, phosphorus, and iron;

c) contribute the niacin, and the small amounts of thiamine and riboflavin, contained in these ingredients.

4. Candies are of high satiety value; eaten after meals, they contribute to the sense of satisfaction and well-being a meal should bring; eaten in moderation between meals, they stave off hunger.

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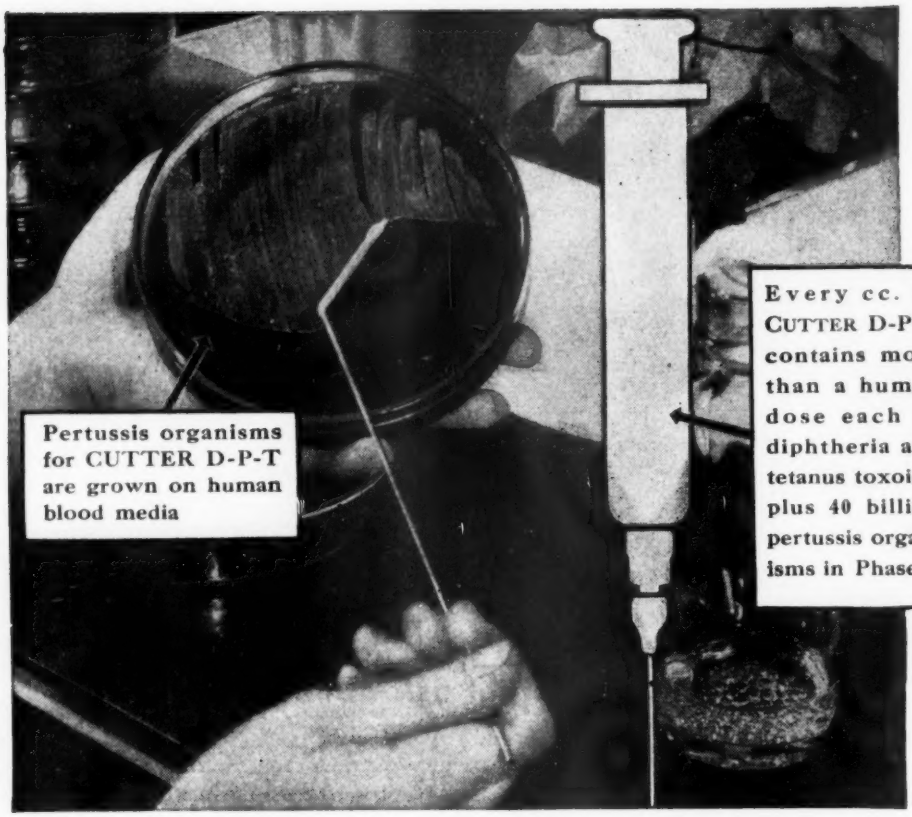

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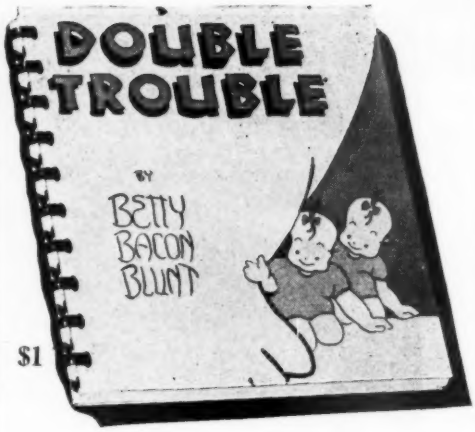

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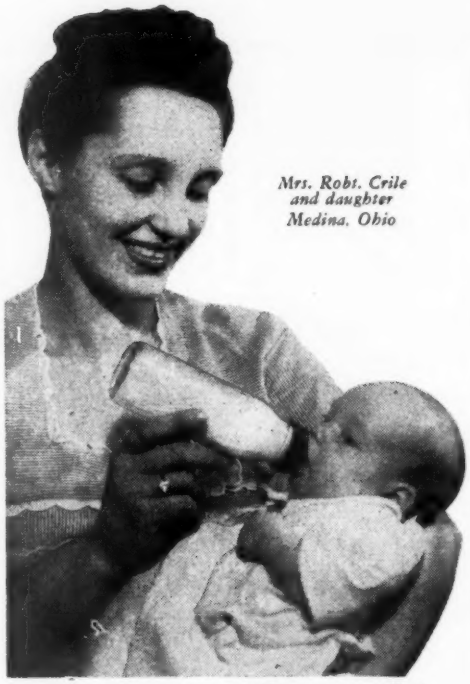

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WANTED—Nurses for Staff Positions in Generalized Public Health Nursing Program located in Suburban Area adjacent to Washington, D.C. Salary $2250 per year. Opportunity for attending Universities part time in Washington, D.C. Reply, Director Nursing Bureau, Arlington County Health Department, Virginia.

WANTED—Supervisor, also staff nurses generalized, public health nursing agency. Apply giving information regarding experience and preparation to Director, Visiting Nurse Association, 194 Concord Street, Manchester, N. H.

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WANTED—Nurse for rural section, Purchase, N. Y., 3 miles from White Plains. Must qualify as Public Health, Visiting, and School Nurse. Prefers younger woman. Can offer annual salary up to $2,000, plus 3 room apartment partially furnished, and clinic. Also allowance for automobile maintenance. Please contact Mrs. Wm. Gilmore at Ophir Farm, Purchase, N. Y., if interested.

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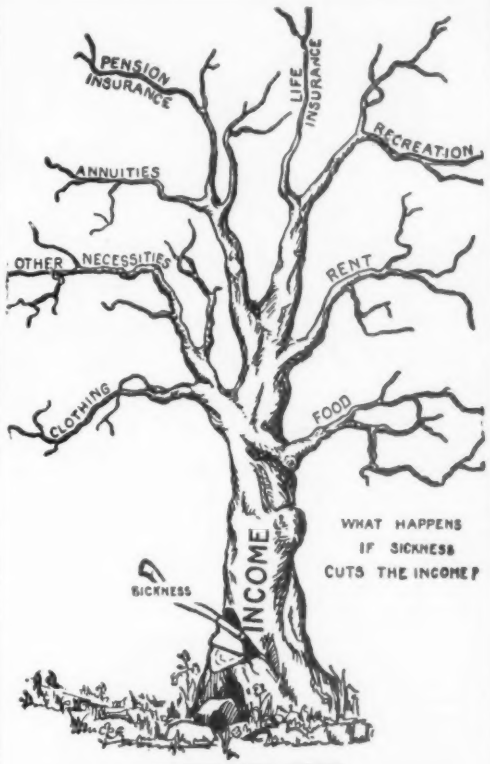

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Epilepsy and the Public Health Nurse	10c
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Nursing Councils: From War to Peacetime	05c
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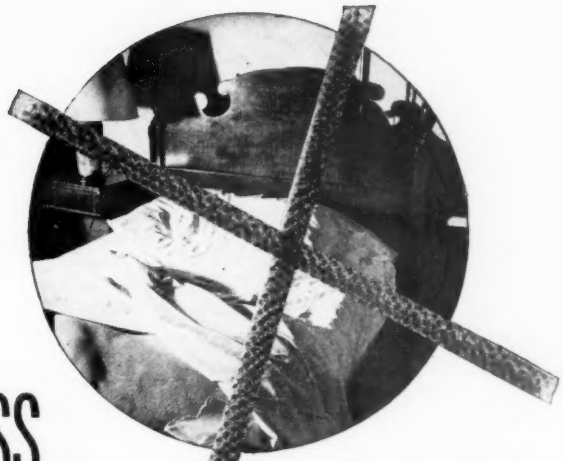

NO MESS...
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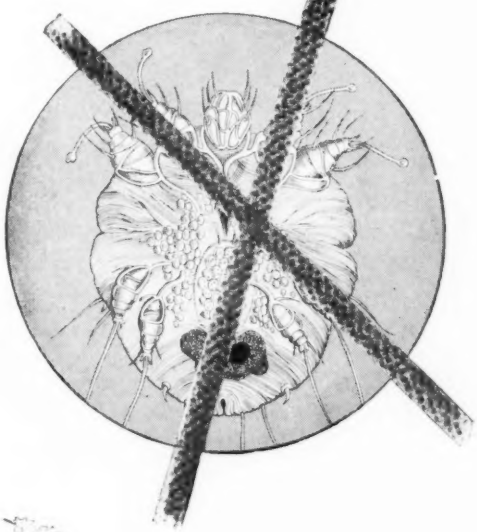
NO SCABIES



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